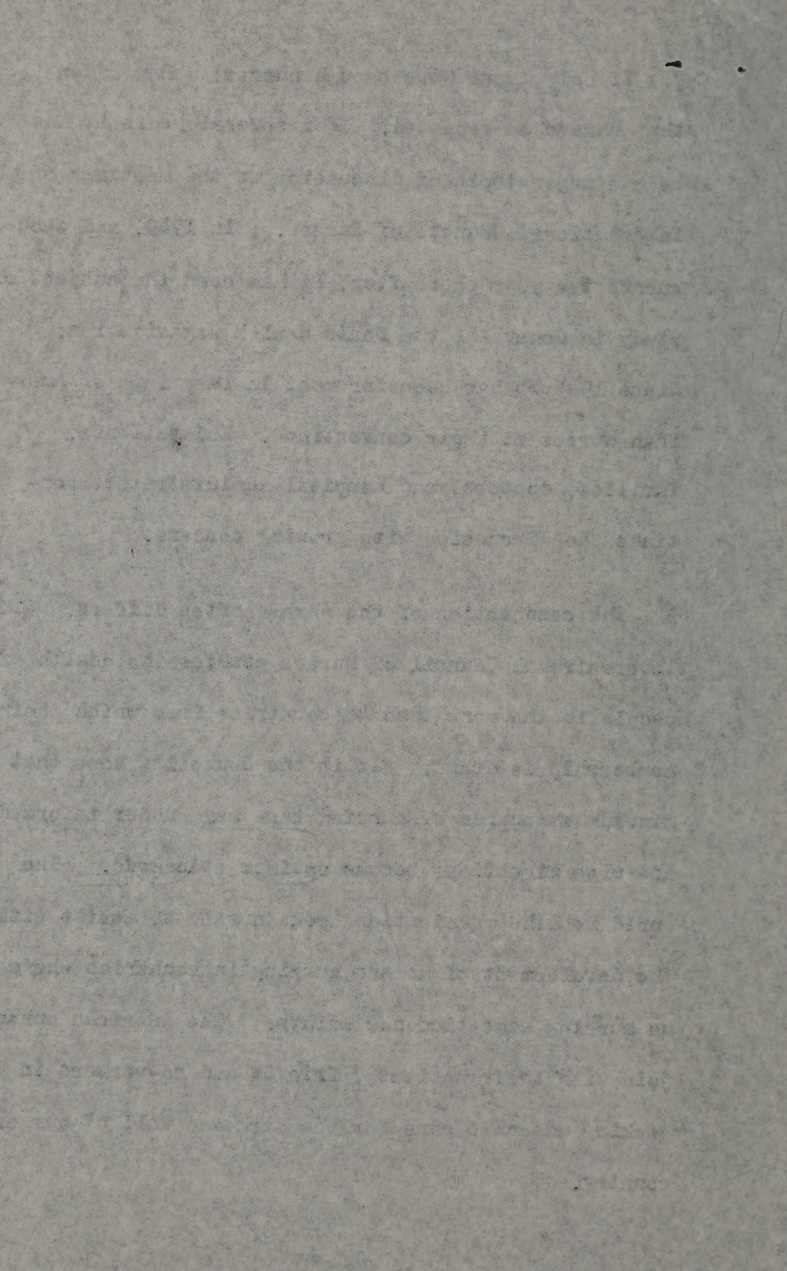


1 D 13 Ruth Steyer 1946 - 1966

1 D 13 - 16 & Quittance before 1950
1950 - 1960

If only there were enough nurses! How often that phrase is repeated. For several years it has been a major topic of discussion at the meetings of the International Council of Nurses. In 1949, and each successive year thereafter, it has been the subject of study in Geneva at the World Health Organization. Since 1945 it has been foremost in the minds of American nurses at their conventions. And patients, families, doctors, and hospital administrators continue the discussion with growing concern.

The connotation of the phrase often differs. The International Council of Nurses studies the health of people in the more than 40 countries from which their membership is drawn. It is the Council's hope that minimum standards of nursing care may, under informed and wise direction, become optimum standards. The World Health Organization seeks nurses to assist with the development of modern nursing in countries where no nursing education now exists. The American nurses join with their patients, friends and co-workers in seeking adequate care for the sick and well of our own country.



This lack of nurses is not just a question of recruitment for schools of nursing. True, in 1946 the admissions to schools in this country dropped below pre-war levels, but each year since that time the enrollment has increased steadily. True, also, 65,000 nurses were in the military service at the time of peak enrollment in 1945, over a quarter of the then active number of registered nurses, and these did not all come marching home to their former positions when the war was over. But it is not true that the modern nurse does not like to care for patients. For the nurses who went to war have gradually returned to civilian positions, inactive nurses have been activated, and students have been graduated from schools of nursing to the extent that in 1950 the estimate of active registered nurses was over 300,000 as against 243,000 in 1945. But where are they all? Last year's estimates show approximately 7,000 more nurses in industrial health services, and approximately 10,000 more in the Veteran's Administration Hospitals than before the war. In addition since 1945 the number of nurses in public health has increased by approximately 6,000, and in civilian hospitals by approximately 75,000. Of these 75,000 63,000 are

This lack of nurses is not just a question of recruitment for schools of nursing. True, in 1946 the admissions to schools in this country dropped below pre-war levels, but each year since that time the enrollment has increased steadily. True, also, 65,000 nurses were in the military service at the time of peak enrollment in 1945, over a quarter of the then active number of registered nurses, and these did not all come marching home to their former positions when the war was over. But it is not true that the modern nurse does not like to care for patients. For the nurses who want to war have gradually returned to civilian positions inactive nurses have been activated, and students have been graduated from schools of nursing to the extent that in 1950 the estimate of active registered nurses was over 300,000 as against 245,000 in 1945. But where are they all? Last year's estimates show approximately 7,000 more nurses in industrial health services, and approximately 10,000 more in the Veteran's Administration Hospitals than before the war. In addition also 1945 the number of nurses in public health has increased by approximately 6,000, and in civilian hospitals by approximately 75,000. Of these 25,000 are

general staff nurses and 12,000 head nurses. Put all together 98,000 nurses have appeared from one source or another during these years, while the question has continued - what has happened to all the nurses?

All this is well enough you may say, but why are there not enough nurses to open our closed beds, or to furnish extra nurses when patients are critically ill, or to answer the many every day calls for private nurses? Yes, this is a matter of arithmetic too, for events have occurred in the world, in the United States, in Boston, and at our own MGH. Strangely similar these events are everywhere, and so similar too are the outcomes; more preventive health care for the well people of the community; hospital care for more of the sick in the population; more accelerated care for the patients in the hospitals. It has been estimated that this country's population will increase by 5,000,000 people between 1950-1954, and that approximately 120,000 additional hospital beds will be added in the country to make care available to more people. In terms of nursing then it is also estimated that whatever gains can be achieved in these same years will probably serve only to maintain the present standard.

General staff nurses and 12,000 head nurses. But
all together 26,000 nurses have appeared from one
source or another during these years, while the question
has continued - what has happened to all the nurses?
All this is well enough you may say, but why are
there not enough nurses to open our closed beds, or to
Turkish extra nurses when patients are critically ill,
or to answer the many day calls for private nurses?
Yes, this is a matter of arithmetic too, for events have
occurred in the world, in the United States, in Eastern
and at our own door. Strangely similar these events are
everywhere, and so similar too are the outcomes; more
preventive health care for the well people of the com-
munity; hospital care for more of the sick in the pop-
ulation; more accelerated care for the patients in the
hospital. It has been estimated that this country's
population will increase by 2,000,000 people between
1920-1950, and that approximately 120,000 additional
hospital beds will be added in the country to make care
available to more people. In terms of nursing then
it is also estimated that whatever gain can be achieved
in these years will probably serve only to maintain
the present standard.

There are other factors which will influence this picture too. New hospital and nursing policies, new medical practices, play a major role in absorbing or reducing the nursing hours at the bedside. At the MOH, for example, a few years ago a blood bank was added - this uses 5 graduate nurses, the central supply room has 1 graduate nurse, the intravenous therapy employ 3 graduate nurses, the new pediatric research project and Ward 4 combined have 9 graduate nurses, the large School has 14 more nurses helping with the teaching, the nursing auxiliary training program has 4 nurses, the affiliation for licensed attendants 2, and so on. Moreover, in 1946 the weekly hour schedule for nurses was reduced. Where 10 staff nurses were needed on night and evening assignments, 12 must now be employed. Where 10 staff nurses were needed on day assignments, 11 3/4 are needed to cover now. Multiply these few changes at MOH by the changes in the country's 6,000 hospitals and the results are astonishing.

Is the question then one of nursing rather than nurses? Should we say - how can we find enough nursing time to meet our needs? But what is nursing if it is not a matter of nurses? We talk of nursing service

There are other factors which will influence this picture too. New hospital and nursing policies, new medical practices, play a major role in absorbing or reducing the nursing hours at the bedside. At the RCH, for example, a few years ago a blood bank was added - this was 5 graduate nurses, the central supply room has 1 graduate nurse, the intravenous therapy service 3 graduate nurses, the new pediatric research project and ward combined have 9 graduate nurses, the large School has 15 more nurses helping with the teaching, the nursing auxiliary training program has 4 nurses, the affiliation for licensed attendants 2, and so on. Moreover, in 1946 the weekly hour schedule for nurses was reduced. Where 10 staff nurses were needed on night and evening assignments, 12 must now be employed. Where 10 staff nurses were needed on day assignments, 11 3/4 are needed to cover now. Multiply these few changes at RCH by the changes in the country's 6,000 hospitals and the results are astonishing.

Is the question then one of nursing rather than nurses? Should we say - how can we find enough nursing time to meet our needs? But what is nursing if it is not a matter of nurses? We talk of nursing service

and nursing care. All too often we speak as if the meanings of the two were synonymous. In any ward or patient unit the activities divide naturally into two different categories. One of these categories includes the activities dealing directly with the care of the patient: the hygienic and therapeutic care in which the nurse participates, the physical, mental, and emotional care given by the nurse, or others substituted for her. This is nursing. The second category includes the services provided so that nursing care and medical care may go on. If the unit is a teaching unit of the hospital some of the nursing services will contribute to the education of doctors, nurses, and other members of the medical science group. The maintenance of clean and attractive surroundings, assistance with the food service, preparation of medical and surgical supplies, keeping of medical, administrative, and teaching records, are all parts of nursing service. All are necessary. All were once done entirely by nurses. Obviously all cannot be done by nurses today.

For many years now the Nursing Department at the MGH has sought an answer to two questions. How can we release nurses from nursing services to save time for

and nursing care. All too often we speak as if the meanings of the two were synonymous. In any ward or patient unit the activities divide naturally into two different categories. One of these categories includes the activities dealing directly with the care of the patient: the hygienic and therapeutic care in which the nurse participates, the physical, mental, and emotional care given by the nurse, or others substituted for her. This is nursing. The second category includes the services provided so that nursing care and medical care may go on. If the unit is a teaching unit of the hospital some of the nursing services will contribute to the education of doctors, nurses, and other members of the medical science group. The maintenance of clean and attractive surroundings, assistance with the food service, preparation of medical and surgical supplies, keeping of medical, administrative, and teaching records, are all parts of nursing service. All are necessary. All were once done entirely by nurses. Obviously all cannot be done by nurses today.

For many years now the Nursing Department at the NIH has sought an answer to two questions. How can we release nurses from nursing services to save time for

nursing care of patients. How can we add personnel trained to assist the nurse to increase the time for patient care. Since 1946 a program of on-the-job training has been conducted to train hospital aides. These men and women are trained to assist with nursing care and to carry certain of the nursing service functions. More ward clerks have been employed and trained to keep certain records and to carry on other non-nursing hostess and secretarial functions. In the spring of 1951 an affiliation was established with the Household Nursing Association School for Attendant Nurses. Students from the Household Nursing Association now come to the Hospital for 13 months to learn to care for patients on medical, surgical, children's and maternity wards.

Instead of a ward staff consisting of graduate nurses or graduate and student nurses, a typical staff now may include graduate nurse, student nurse, graduate licensed attendant and student attendant or hospital aide. That the patient may not be harassed by a constant change of workers, or feel insecure because of lack of skill in the lesser trained worker, the nurses

nursing care of patients. How can we add personnel
trained to assist the nurse to increase the time for
patient care. Since 1946 a program of on-the-job
training has been conducted to train hospital aides.
These men and women are trained to assist with nursing
care and to carry certain of the nursing service functions.
More ward clerks have been employed and trained to keep
certain records and to carry on other non-nursing hospital
and secretarial functions. In the spring of 1951 an
affiliation was established with the Household Nursing
Association School for Attendant Nurses. Students
from the Household Nursing Association now come to the
Hospital for 15 months to learn to care for patients on
medical, surgical, children's and maternity wards.
Instead of a ward staff consisting of graduates
nurses or graduates and student nurses, a typical staff
now may include graduate nurse, student nurse, graduate
licensed attendant and student attendant or hospital
aides. That the patient may not be harassed by a constant
change of workers, or feel insecure because of
lack of skill in the lesser trained worker, the nurses

and members of the auxiliary personnel are grouped into working units called patient teams, and are assigned to a group of patients to give the nursing care. The nurse is the leader who plans the work with the head nurse, assigns functions to the team members, works with or beside the team members to guide, evaluates their work, and passes on a report of the patients' needs to the next team. The team benefits by the leadership and cooperative spirit of the group; the patient benefits by the better integrated service, the unity of the group, and the pride of the team in its accomplishments. The Hospital benefits because fewer nurses are needed and team members as a whole, including nurses, find satisfactions and tend to remain with us for longer periods of time.

Wards must have head nurses, teams must have leaders, and sick patients must have personal attention and care, so the search for graduate nurses must continue in order that MGH and the patients who come to the MGH may have their rightful share of the country's supply. Two weeks ago the Phillips House nursing staff began a refresher course to help inactive nurses return to active service. In September the Baker Memorial inaugurated a plan for

and members of the auxiliary personnel are grouped into
working units called patient teams, and are assigned to
a group of patients to give the nursing care. The nurse
is the leader who plans the work with the head nurse,
assigns functions to the team members, works with or
beside the team members to guide, evaluates their work,
and passes on a report of the patients' needs to the
next team. The team benefits by the leadership and
cooperative spirit of the group; the patient benefits by
the better integrated service, the unity of the group, and
the pride of the team in its accomplishments. The
Hospital benefits because fewer nurses are needed and
team members as a whole, including nurses, find satisfac-
tion and tend to remain with us for longer periods of
time.

Wards must have head nurses, teams must have leaders,
and sick patients must have personal attention and care,
so the search for graduate nurses must continue in order
that NOW and the patients who come to the NOW may have
their rightful share of the country's supply. Two weeks
ago the Philippine House nursing staff began a refresher
course to help inactive nurses return to active service.
In September the Baker Memorial inaugurated a plan for

for the training of team leaders. Typical of our previous findings, the public discussion of the team plan of assignment brought a dual result, for there was also an increase in applications from licensed attendant nurses. The General Hospital has taken leadership in the staff education program for graduate nurses of all divisions. The School of Nursing in September completed the third year of an experimental program planned to test the possibility of preparing nurses in less than three years' time.

But all this will not result satisfactorily if the present turnover continues in the staff nurse and head nurse groups. It has not been uncommon to have the turnover reach 100% of the total number of staff nurses in a year. This points to national factors such as general unrest, or competitive salary schedules. It also emphasizes the need for the MGH to keep in step with national changes, to provide a working situation which will stimulate the nurse and help her to find satisfaction in her work. And finally it points to the urgent need for improving living conditions for the graduate nurse, which will make her wish to choose MGH as her hospital.

for the training of team leaders. Typical of our previous findings, the public discussion of the team plan of assignment brought a good result, for there was also an increase in applications from licensed attendant nurses. The General Hospital has taken leadership in the staff education program for graduate nurses of all divisions. The School of Nursing in September completed the third year of an experimental program planned to test the possibility of preparing nurses in less than three years' time.

But all this will not result satisfactorily if the present turnover continues in the staff nurse and head nurse groups. It has not been uncommon to have the turnover reach 100% of the total number of staff nurses in a year. This points to national factors such as general raised, or competitive salary schedules. It also emphasizes the need for the NCM to keep in step with national changes, to provide a working situation which will attract the nurse and help her to find satisfaction in her work. And finally it points to the urgent need for improving living conditions for the graduate nurse, which will make her wish to choose NCM as her hospital.

Not an MGH need, but a world-wide problem. Not a shortage of nurses but an overdemand for nursing services. Not only too few nurses but too little time to nurse. A problem of growing need versus growing numbers. A problem of the worker in a highly competitive market, the result of modern medicine, and the quest for health.

December 10, 1951

Not an RMR need, but a world-wide problem. Not

a shortage of nurses but an overabundance for nursing

services. Not only too few nurses but too little

time for nurses. A problem of growing need versus

growing numbers. A problem of the worker in a

highly competitive market, the result of modern

medicine, and the quest for health.

NEW ENGLAND HOSPITAL ASSEMBLY

Section on Nursing

Wednesday, March 28, 1951

Better Coordination of Hospital Services for the Care and Teaching of the Patient

Nurse: Miss Ruth Sleeper, R.N.
Director of the School of Nursing and Nursing Service
Massachusetts General Hospital
Boston, Massachusetts

For the purpose of this discussion I should like first to discuss nursing. Unfortunately, I cannot be as clear in my definition as Florence Nightingale was in the subtitle she chose for her book called "Notes on Nursing - What It Is and What It Is Not". Like others today I cannot be sure whether we know just what nursing is. When there was no social worker, no dietician, no housekeeping department, no laundry supervisor, it was a simple matter to define the functions of the nurse. She combined the functions of many present day hospital workers caring for the patients' environment and giving the care not considered the responsibility of the doctor. The doctor, the hospital superintendent, and the nurse were the hospital. Gradually specialists of many types were added to do better the work the nurse was neither prepared nor given time to do. With these additions the hospital service to the patient was greatly improved. But with the advent of these workers came many problems for the hospital administration, the doctor, the nurse, and most important of all this improved service brought heretofore unrealized problems to the patient.

Rather than define nursing I shall divide it into two areas of activity: nursing service and patient care. Nursing service includes the maintenance of the patient's environment, the ordering and care of supplies, the provision of facilities and equipment needed by the doctor and the nurse, or other professional workers in caring for the patient. Nursing service may also include the assignment, management and teaching of the personnel involved

either in furnishing the service or in giving the actual patient care. Nursing care on the other hand is the activity actually carried on directly with or for the patient.

The fact that the nurse actually gives two types of service in the performance of her function requires that she coordinate her activities with two different groups of workers in the hospital. First, there are those other departments which also give services essential to the welfare, safety, and medical care of the patient, such as the pharmacy, the store, the laundry, maintenance and the like. With those departments the nurse must work and maintain the proper inter-group relationships if the patient is to be physically comfortable, free from annoying noises, or sights, warm, clean, supplied with medicines and the equipment his care requires. Second, there is the group of workers who like the nurse contact the patient directly, such as the doctor, the dietitian, the social worker, the physical therapist, the occupational therapist, the laboratory technician. With these the nurse must also work and have constructive relationships if the care of the patient is to follow a well ordered plan in which no one element conflicts with or negates another.

The nurse occupies in the hospital what at times is an enviable position. She is always with the patient. Other departments and professional workers come and go, but throughout the twenty-four hours for seven days a week a nurse remains. In the absence of the maintenance department she must know whether the electrical equipment is safe. In the absence of the doctor she must know how to answer the patients' queries, and if necessary modify the treatment until the doctor can be reached. When the dietician goes home she should be able to meet the situation if questions pertaining to food arise. She can help or hinder as she is prepared and as hospital and medical policies permit her to function. Moreover, this nurse is with the patient after doctor, social worker and others have completed their daily calls. She cannot

help but observe the effects on the patient of the many workers who come one after the other, each with his or her own special interest to pursue, unaware often of the never-ending stream of workers and the strain this constant adjustment to many people may bring, not realizing that between doctor, social worker, dietitian, laboratory technician, there is no time for the patient to rest, or even to make the adjustment to one before the next appears; no time to gather strength after the pain of the dressing to have any interest in the tray which immediately appears.

Now all of this conglomeration of workers are by no means from other departments. The Nursing Department itself has often enough workers today to confuse the patient. In the effort to meet the shortage of nurses, auxiliary workers have been added; the licensed attendant, the trained-on-the-job-aide, the orderly, the ward clerk, the ward helper, the volunteer. Tasks have sometimes been assigned on the Ford factory system, because it is more efficient in terms of clock hours to have each worker perform one special task. One passes trays, one fills pitchers, one makes the bed, one gives the medicines, etc. The result is, of course, that the Nursing Department adds its workers to the never-ending stream going into the patient's room. One patient on a gynecological ward floor was kind enough to note on a slip of paper whenever someone came into her room to carry out a procedure, visit or clean. From 7 a.m. to 7 p.m. this patient was approached for one purpose or another 44 different times. As we think about this patient's adjustments it should be noted that whether from exhaustion or writers cramp there are no notations between 2:30 and 3:50. It seems probable that asleep or awake someone must have at least looked into her room during that hour and twenty minutes. It seems significant enough to take time to list the various individuals who visited this patient: head nurse and assistant, nurses on the floor; two doctors; hospital aide; ward helper; ward clerk; social worker;

librarian; medical student; volunteer; Red Cross Aide; ward maid. I am glad to report that in addition to these 44 visitors the patient's husband also arrived at 6 p.m. and also would like to state that this is not an exaggerated or inflated example. Obviously, someone on the staff should be giving consideration to the patient under such circumstances.

There is need for coordination at the patient's level. The doctor is naturally the person who might effect this coordination, but he is on the floor usually but a short time. We might choose next the head nurse, who being in charge of the floor could plan a schedule for the patient to allow for the rest a hospital stay should provide. But, if we consider the situation of the head nurse, she like the patient is meeting and adjusting to an unending stream of professional and non-professional workers. Coordination cannot be brought about by one worker. There must be time to think and plan with all concerned. Consider the position of the head nurses on two semi-private floors. The capacity of these floors is 37 beds each. For most of the week all beds are occupied. On an average day, by actual count, on the medical floor from 7 a.m. to 7 p.m. 70 doctors come to see one or more patients; 41 of these doctors come before one o'clock in the afternoon; 15 came between 10 and 11 o'clock in the morning. On the surgical floor there were 55 doctors visit; 31 of which were made before one o'clock. Many of these doctors changed orders for their patients.

To carry out the doctor's orders, give the nursing care, and maintain the floor service, these head nurses had staffs composed of workers of widely varying backgrounds, as well as responsibilities: graduate staff nurses; third, second, and first year student nurses; licensed attendants; hospital aides; orderlies; ward helpers; ward clerks. It was necessary to send patients to X-ray and on one floor to the Operating Room. Laboratory technicians came from several laboratories to carry out different procedures.

The dietitian needed to discuss certain patients. A few words were needed with the housekeeping department supervisor. Certainly, there is need for coordination of activities which affect patient care at the head nurse level, if that care is to be satisfactory, if the patient is to feel secure and happy in his care and if the personnel are to do their best work and find satisfaction in their jobs.

We in nursing have been increasingly concerned over this growing complexity of the hospital's services, and its affect on the care of the patient and the efficiency of the personnel. As a first step toward a solution of the patient's dilemma in respect to nursing care, we have tried to coordinate nursing care through the use of a so-called "bedside care team". In this plan a graduate staff nurse or a senior student as team leader is assigned the responsibility for a group of patients. The head nurse and the team leader review the plan for the patients' care, including medical and nursing care. It is then the responsibility of the team leader to assign each member of the team to give those aspects of the care for which they are prepared, to work with each member as the situation demands, to supplement the work of the auxiliaries, to give those aspects of the care the auxiliaries are not prepared to give, and to so manage the situation that the patient feels secure in his care, and that the nurse leader of the team knows him as an individual and sees and understands his needs, emotional as well as physical.

But this team answers only a part of the problem on the ward. A second group is also necessary. Perhaps we might call this a planning team, composed of doctor and head nurse, with dietitian, social worker, physiotherapist and occupational therapist, as they are active in the patient's care. This team in which the doctor should be the leader should make the over-all plan for the patient's care with the patient's comfort and welfare as the central focus, and should coordinate all ward activities in such a way as to make clear to all concerned that the purpose of the ward staff is a patient centered one.

But coordination cannot end on the patient floors. These two teams will succeed or fail as the attitude of the chiefs of the medical and surgical staffs, the hospital administration, the director of nursing, and other department heads understand each other's problems and carry on coordination at top level, through comparable planning sessions. If hospital policies are determined after free discussion and consideration of their affect on all departments, if nursing and other departments affected are notified of pertinent changes in research activities, or new plans for patients in time to prepare for the changes before they occur, if when there are conflicts, errors or omissions involving nursing, these are talked over constructively with the appropriate officer of the nursing department at an appropriate time, then the floor teams may be expected to succeed.

The same plan holds true in respect to other services necessary to maintain the safe and attractive environment for the patient. Perhaps in this respect the department head conference with the hospital director becomes a coordinating mechanism. Certainly, the attitudes built in these sessions by the hospital administrator cannot but succeed in paving the way for good group relationships, at the department head level, and the directors of the pharmacy, personnel, store, and housekeeping departments will find the way paved for coordination with nursing on all levels.

The problem of improving the teaching of the patient seems to require more than coordination of services. Basic to this question seems to be a fundamental disagreement as to the function of the nurse. The doctor of public health, the nurse and the patient, too, see this as an important responsibility of the nurse. The doctor may or may not agree that this activity is rightly included in nursing. Or if the doctor acknowledges that the nurse may teach, he often does not agree with his medical co-workers on

the content for which the nurse should assume responsibility. No nurse would presume to question the fact that the doctor does a great deal of teaching. But many patients and nurses will tell of instructions given at a time when emotions or other factors distracted attention from the teaching, or when all of the doctor's discussion could not be absorbed at one brief visit. It is, therefore, natural that the patient may wish to think the instructions through with the nurse who has longer to spend at the bedside, or who arrives at just the right moment to talk. The nurse also can easily have contact with the visiting nurse who can give her necessary information on the home situation in which the patient must continue his care. The nurse plays a large part in the referral form sent on the patient's discharge to the Visiting Nurse Service. She sees the notations of doctor, dietitian and often social worker on these forms. Gaps in the preparation of the patient for discharge must be recognized, discussed with the doctor, the visiting nurse and the patient. Surely the nurse should be trusted with the proper safeguards to carry on a practical plan for teaching the patient when this is necessary. Basic to such differences of opinion lie lack of understanding of the nurse's situation preparation, ability, interest, and intent.

In nursing we are beginning to teach our students in their formative years to work in teams with the auxiliary workers to the end that on graduation the nurse knows the place of each worker, and respects each member of the team for his or her contribution.

Is it not time that more of the students in the various professional groups, contributing to the patient's care, also learned as students to work together and to respect each other's contribution. Could the medical student not benefit by being a member of the ward team - not as the substitute for the interne to give orders - but through well planned clinics or rounds to participate with student nurse, licensed attendant and aide in such a way

as to see and appreciate the place of all in the patient's care.

The nurse does not wish to assume the functions of the doctor or any other professional worker. Her hands are already full to overflowing. What she does want is to be given understanding cooperation which will enable her to contribute her full share to the patient's care, his physical and emotional adjustment to his illness, to the hospital surroundings, to his treatment, and finally to share in the preparation of the patient for his return to his family where he will recover, or with help will rehabilitate himself successfully.

During the past ten years the Nursing Service has established and maintained a closer working relationship with the Medical Service. From the beginning, this has required increased communication and cooperation at all levels of the Medical and Nursing Service staffs. This was facilitated greatly by locating the office of the Supervisor of Medical Nursing in juxtaposition to that of the Chief of the Medical Service, her attendance at the weekly meetings of the Chief of the Medical Service with the residents and her meeting at regular intervals with the members of the house staff and the nurses in charge of the medical wards. These interservice meetings have led to better understanding of the problems that arise on the medical wards. It is in this setting that the members of the ward team (physicians, nurses, medical and nursing students) become increasingly cognizant of their respective roles, present and future. In this brief statement, I wish to call attention to the increasing role of the nurse on the Medical Service in the care of patients and medical research.

She has become more proficient in recognizing the many symptoms of illness and in carrying out the ever increasing complex therapeutic procedures. She aids both the patient and the physician, attempting to interpret each to the other, thereby making the relationship more fruitful and pleasant. She is the link between the doctor and the patient. I believe she is very aware that - "Whether the link jars or jangles, or whether it functions without friction, depends on what went into its forging". I trust that many doctors have like insight.

The nurse serves as the liaison between the patient and the doctor, clarifying his instructions, reinforcing his assurances, illuminating whatever may be obscure, administering and carrying out whatever may have been

prescribed, whether medicinal or not. This is no easy task but one which she tries hard to discharge. She has become an increasingly skilled observer and interpreter of the patient's reactions, both physical and emotional, reporting not only the behavior and measurement of various bodily functions, but also his fears, anxieties, or abnormal behavior. In the real sense, she strives hard to supply the doctor with another pair of trained hands, another pair of discerning and discriminating eyes. This dual role of the doctor's ally and patient's supervisor, companion or confidant is not an easy one, but when skillfully played, the results have been immensely gratifying to all concerned.

That considerable skill and tact are required to accomplish this, there can be no doubt, since the nurse has an obligation to both the patient and the doctor. In most instances, these loyalties are not in conflict, for the patient's welfare is the overriding concern. Occasionally, however, when a gulf appears between patient and doctor, for whatever reason, it is the skillful nurse who unobtrusively but effectively narrows or eliminates it. Problems of this sort do arise on a busy medical ward where several doctors may be engaged in the care of a single patient.

Nowhere is the nurse's role as an interpreter and physician's ally so valuable and helpful as in clinical research. Depending upon the nature of the investigation, there may be repetitious observations, meticulous collection of specimens, and the ingestion of monotonous or unpalatable diets, sometimes for prolonged periods. The nurse indoctrinates the patient in the cause of research and their own contribution to it. The cooperation and enthusiasm of the patient will often depend on the encouragement and explanation and how well the nurse communicates the nature and purpose of the study. Above all, she takes the lead in promoting his happiness during his

prescribed, whether medicinal or not. This is no easy task but one which she finds hard to discharge. She has become an increasingly skilled observer and interpreter of the patient's reactions, both physical and emotional, reporting not only the behavior and measurement of various bodily functions, but also his fears, anxieties, or abnormal behavior. In the real sense, she strives hard to supply the doctor with another pair of trained hands, another pair of discerning and discriminating eyes. This dual role of the doctor's ally and patient's supervisor, companion or confidant is not an easy one, but when skillfully played, the results have been immensely gratifying to all concerned. That considerable skill and tact are required to accomplish this, there can be no doubt, since the nurse has an obligation to both the patient and the doctor. In most instances, these loyalties are not in conflict, for the patient's welfare is the overriding concern. Occasionally, however, when a gulf appears between patient and doctor, for whatever reason, it is the skillful nurse who unobtrusively but effectively narrows or eliminates it. Problems of this sort do arise on a busy medical ward where several doctors may be engaged in the care of a single patient. Nowhere is the nurse's role as an interpreter and physician's ally so valuable and helpful as in clinical research. Depending upon the nature of the investigation, there may be repetitious observations, meticulous collection of specimens, and the ingestion of monotonous or unpalatable diets, sometimes for prolonged periods. The nurse indoctrinates the patient in the cause of research and their own contribution to it. The cooperation and enthusiasm of the patient will often depend on the encouragement and explanation and how well the nurse communicates the nature and purpose of the study. Above all, she takes the lead in promoting his happiness during his

stay on the ward.

It is more apparent today than ever before that whenever the physicians of the Medical Service deal with patients, little could be accomplished without the invaluable aid of the discerning and understanding nurse. This is due to the fact that our nurses have been trained to act as the doctor's ally and colleague in the healing art and in helping patients toward a more positive approach to health. This augurs well for the future.

The Psychiatric Service of the Massachusetts General Hospital has just celebrated its 25th anniversary. It was started by Dr. Stanley Cobb to satisfy three basic concerns. First, facilities were needed for the care of the acute mental disturbances which may develop in the course of medical or surgical diseases. Second, those patients whose complaint and impairment were primarily due to psychogenic causes in the form of psychoneuroses or psychosomatic disorders needed resources for competent psychotherapy and a suitable environment for such therapy. Third, the many issues of emotional conflict, lack of cooperation on the part of the patients, and the reactions to serious social strain in the family and the community which interfere with the patient's motivation for recovery had to be understood and handled wisely to strengthen the overall program of medical care.

To serve these functions a special ward was developed which required highly organized teamwork between the psychiatrists and the nursing staff to provide an optimal environment for patients with emotional difficulties. A good many of such patients are not bed patients in the narrow sense but have to be active and occupied in a suitable manner throughout the day. Much understanding and emotional support is required on the part of the nurses, and many organizational problems arise on the ward as we try to integrate psychiatric nursing care, occupational therapy, and activity programs and to relate all of these to effective psychotherapy. The nurse becomes a much valued observer of the subtleties of emotional adjustment and plays a key role in the support of the emotionally deprived and conflict-ridden persons during critical periods. Confusion and depression, suicidal tendencies and suspicions have to be accepted, tolerated, and understood in a constructive manner in order to help the patient master a given life

The Psychiatric Service of the Massachusetts General Hospital has just celebrated its 25th anniversary. It was started by Dr. Stanley Cobb to satisfy three basic concerns. First, facilities were needed for the care of the acute mental disturbances which may develop in the course of medical or surgical diseases. Second, those patients whose complaints and impairment were primarily due to psychogenic causes in the form of psychoneuroses or psychosomatic disorders needed resources for competent psychotherapy and a suitable environment for such therapy. Third, the many issues of emotional conflict, lack of cooperation on the part of the patients, and the reactions to serious social strains in the family and the community which interfere with the patient's motivation for recovery had to be understood and handled wisely to strengthen the overall program of medical care.

To serve these functions a special ward was developed which required highly organized teamwork between the psychiatrists and the nursing staff to provide an optimal environment for patients with emotional difficulties. A good many of such patients are not bad patients in the narrow sense but have to be active and occupied in a suitable manner throughout the day. Much understanding and emotional support is required on the part of the nurses, and many organizational problems arise on the ward as we try to integrate psychiatric nursing care, occupational therapy, and activity programs and to relate all of these to effective psychotherapy. The nurse becomes a much valued observer of the subtleties of emotional adjustment and plays a key role in the support of the emotionally deprived and conflict-ridden persons during critical periods. Confusion and depression, suicidal tendencies and suspicious have to be accepted, tolerated, and understood in a constructive manner in order to help the patient master a given life

crisis. It is this "psychodynamic" approach to the patient's problem which has necessitated such close teamwork of all the caretaking staff and has required a high level participation of the nurses in the therapeutic program. Her spontaneity and resourcefulness is often a key to the solution of behavioral emergencies. We have been most fortunate in being able to rely on the enthusiasm and dedication and on the high level of competence of the nurses assigned to our service.

As both nurses and staff developed progressively more insight and skill in psychiatric therapy, it became possible to make use of this competence throughout the other services of the hospital. The psychiatric consultant has been able to count on understanding cooperation of the nurses in the solution of the psychological aspects of patient care. Indeed, there has developed a natural alliance between the psychiatrists operating as "medical anthropologists" and the nurses, since both are oriented towards the patient as a person and as a social being more than being concerned with the specific organs involved in a given illness.

As the style of care in the general hospital has moved in the direction of greater technology, more rapid turnover, and more intensive therapeutic measures of short duration, the necessity for emotional support of the patients during these critical periods has become more urgent, and the psychiatrist has been in a special position to witness and to appreciate the tremendous contribution which the high level of competence of the nurses in the area of psychological and human relation issues has made possible. ^{Nursing} ~~Miss Sleeper~~ was quick to take advantage of the skills in "mental health consultation" which the Psychiatric Department developed in its new Mental Health Service. Several discussion groups were organized between nurses, psychiatrists, and psychologists at various levels of the organization

crisis. It is this "psychodynamic" approach to the patient's problem which has necessitated such close teamwork of all the caretaking staff and has required a high level participation of the nurses in the therapeutic program. Her spontaneity and resourcefulness is often a key to the solution of behavioral emergencies. We have been most fortunate in being able to rely on the enthusiasm and dedication and on the high level of competence of the nurses assigned to our service.

As both nurses and staff developed progressively more insight and skill in psychiatric therapy, it became possible to make use of this competence throughout the other services of the hospital. The psychiatric consultant has been able to count on understanding cooperation of the nurses in the solution of the psychological aspects of patient care. Indeed, there has developed a natural alliance between the psychiatrists operating as "medical anthropologists" and the nurses, since both are oriented towards the patient as a person and as a social being more than being concerned with the specific organs involved in a given illness.

As the style of care in the general hospital has moved in the direction of greater technology, more rapid turnover, and more intensive therapeutic measures of short duration, the necessity for emotional support of the patients during these critical periods has become more urgent and the psychiatrist has been in a special position to witness and to appreciate the tremendous contribution which the high level of competence of the nurses in the area of psychological and human relation issues has made possible. Miss Glasgow was quick to take advantage of the skills in mental health consultation" which the Psychiatric Department developed in its new Mental Health Service. Several discussion groups were organized between nurses, psychiatrists, and psychologists at various levels of the organization

of nursing services leading to a remarkable exchange of insights and of techniques for solving psychological and interpersonal problems which affect not only the recovery of certain patients but also the happy and affective functioning of the caretaking personnel. The results of this type of cooperative endeavor were particularly useful when new forms of patient care were organized such as the Rehabilitation Service. The problem of the motivation of patients and personnel and the development of new role functions of the different professional groups were central to this development, since the program includes educative measures at least as much as therapy.

In summary, both in the psychiatric care proper which goes on on Wards B-7 and B-8 and in the "infiltrating" components of psychiatric work in cooperation with other services, the participation of the nurses has been crucial for the development of the type of General Hospital Psychiatry which is recognized as one of the contributions of the Massachusetts General Hospital to the improvement of medical care.

of nursing services leading to a remarkable exchange of insights and of techniques for solving psychological and interpersonal problems which affect not only the recovery of certain patients but also the happy and effective functioning of the caretaking personnel. The results of this type of cooperative endeavor were particularly useful when new forms of patient care were organized such as the Rehabilitation Service. The problem of the motivation of patients and personnel and the development of new roles functions of the different professional groups were central to this development, since the program included educative measures at least as much as therapy.

In summary, both in the psychiatric care proper which goes on on Wards B-7 and B-8 and in the "infiltrating" components of psychiatric work in cooperation with other services, the participation of the nurses has been crucial for the development of the type of General Hospital Psychiatry which is recognized as one of the contributions of the Massachusetts General Hospital to the improvement of medical care.

Stretching the Nurse

RUTH SLEEPER, R.N.

Sleeper

Stretching the nurse -- it sounds so intriguing. What possibilities, if we could actually stretch one precious staff nurse into two, or three, or even more. My thoughts jump immediately to the paper cut-outs of my childhood, where with paper properly folded, the scissors traced the shape of one child. Then immediately the paper opened and there were five or even ten children, holding hands and marching along together.

Could we, perhaps, visualize some way to stretch a nurse which would produce a whole chain of new nurses? Perhaps it would be miracle enough if we could set up a chain of events so that many people, some of them nurses, might march along together to meet the demands that nurses alone could not meet. How good it would be, after all these years of pressures and apologies, to be able to have a positive answer for hospital administrators and doctors; and especially for patients.

NURSING SHORTAGES

We have repeated the causes for our inadequate numbers over and over; the growing population, the aging population, the expansion of voluntary health insurance, increased use of hospital beds, the building of more hospitals, advances in medical science, the extension of public health service and the needs of the military. It has seemed, sometimes, as if this recitation of the causes of our shortage might help to excuse our inability to stem the tide of

Sketching the Nurse

JOHN SLEETER, R.N.

Sketching

Sketching the nurse — it sounds so intriguing. What points
sketches, if we could actually sketch one previous staff nurse into
two, or three, or even more. My thoughts jump immediately to the
paper cut-outs of my childhood, where with paper and pencil, the
sketches traced the shape of one child. Then immediately the
sketches and there were five or even ten children in the same and
sketching along together.

Could we, perhaps, visualize some way to sketch a nurse's
would produce a whole chain of new nurses? Perhaps it would be
miracle enough if we could put up a chain of events so that many
people, some of them nurses, might sketch along together to meet the
demands that nurses alone could not meet. How good it would be, af-
ter all these years of nursing and apologetics, to be able to have
a positive answer for hospital administrators and doctors; and es-
pecially for patients.

HUNTING SHORTAGES

We have reported the causes for our inadequate numbers over and
over; the growing population, the aging population, the expansion
of voluntary health insurance, increased use of hospital beds, the ex-
panding of some hospitals, advances in medical science, the expan-
sion of public health service and the needs of the military. If
has seemed, sometimes, as if this recitation of the causes of our
shortage might help to excuse our inability to stem the tide of

Sleeper---2

demand.

But we could not forget the other side of the picture. Too often, regardless of the soundness of our reasoning, we have felt a sense of blame. In spite of the fact that almost half of the country's 334,733 professional nurses are employed in hospitals, patients in some hospitals had inadequate care. General hospitals throughout the country average one nurse to every three patients, a deceiving figure indeed -- some hospitals with special services and schools have better than one to three and other hospitals have too few professional nurses to give the needed care or even to give proper supervision to auxiliary workers, whose preparation varies from adequate to none at all. Then there are the mental hospitals, with an average of one nurse to 13 patients. We must face the fact that some hospitals have only one nurse to several hundred. And in all hospitals, the patients' chances for recovery depend in part upon their nursing care.

The public health picture is brighter in many communities. We are told that only 13 incorporated cities with populations of 10,000 or more do not have nurses in full-time public health work. But many people live in smaller communities, and rural areas, who still lack this valued service. The public health nurse must begin where the hospital nurse leaves off; and in these days of earlier discharges, she will carry a part of the nursing care formerly given by the hospital nurse.

ANSWERS NEEDED

You know all this. You, as I, have doubtless recited the list

MORE

Slip--2

many times. You have finally faced the situation and admitted to it.

But we could not forget the other side of the picture. Too often, the hospitals of the country are not doing what they should be doing. In spite of the fact that almost half of the country's 334,732 professional nurses are employed in hospitals, patients in some hospitals are not getting the best care. Our hospitals throughout the country average one nurse to every three patients, a decreasing figure indeed -- some hospitals with a special medical and surgical unit have fewer than one to three and others still have two. The professional nurses to give the best care of even to give proper supervision to auxiliary workers, whose supervision varies from a delegate to none at all. Then there are the mental hospitals, with an average of one nurse to 10 patients. We must face the fact that some hospitals have only one nurse to several hundred, and in all hospitals, the patients' chances for recovery depend in part upon their nursing care.

The public health picture is not better in many communities. We have found that in incorporated cities with populations of 10,000 or more do not have nurses in full-time public health work. But many people live in unhealthful communities, and rural areas, who still lack this valued service. The public health nurses must begin where the need is most urgent; and in these days of earlier diagnosis, they will carry a part of the nursing care formerly given by the hospital nurses.

You know all this. You, as I, have doubtless recited the list

Sleeper---3

many times. You have finally faced the situation and admitted to yourself that there will not be enough professional nurses, at least for years to come. So, other ways must be found to meet the obligations which rightly fall upon us.

We must stretch our nursing to encompass our obligations, but we cannot stretch a vacuum. Recruitment must continue. Better and more recruitment of students for nursing and students for practical nursing is needed. We need have no cause for embarrassment: In these years when fewer girls are of an age to graduate from high schools our national recruitment has surpassed that of the rewar years. More nurses are practicing nursing than ever before. Over half of these practicing nurses are married. Active state league committees on recruitment, and others, will help to produce more graduate nurses in 1957, provided the students find satisfaction in good schools with programs which stimulate and hold interest. Constant study of school programs by the school faculties, the use of accreditation and consultation services of the National League for Nursing can help to develop schools which attract applicants and retain students. This is our bank account for the future -- more and better recruiting.

APPROPRIATE DUTIES

The times now demand that we employ and assign nurses for nursing. This is not a new idea. Neither has this idea been completely accepted, although it is often repeated. How many hours might be gained if all housekeeping activities were transferred to the

Speaker--J

many times. You have finally faced the situation and admitted to yourself that there will not be enough professional nurses, at least for years to come. So other ways must be found to meet the obligations which rightly fall upon us.

We must stretch our nursing to encompass our obligations, but we cannot stretch a vacuum. Recruitment must continue. Better and more recruitment of students for nursing and training for practical nursing is needed. We need have no cause for pessimism. In these years when fewer girls are of an age to graduate from high schools our national recruitment has surpassed that of the former years. More nurses are practicing nursing than ever before. Over half of the practicing nurses are married. Active state leagues maintain an interest in and report will help to produce more graduate nurses in 1937. Provided the students find satisfaction in good schools with programs which stimulate and hold interest. Continued study of school programs by the school faculties, the use of coordination and consultation services of the National League for Nursing can help to develop schools which attract applicants and retain students. This is our bank account for the future -- more and better recruiting.

APPROPRIATE UTILITY

The times now demand that we employ and assign nurses for nursing. This is not a new idea. Neither has this been completely accepted, although it is often repeated. How many hours might be gained if all housekeeping activities were transferred to the

Sleeper---4

housekeeping department? How many more would be saved if the dietary department assumed full responsibility for the patients' tray service, or if the hospital operated a central supply room which completely serviced the wards? On large floors, what would it mean in patient care time if an aide serviced the utility rooms and all of the equipment? A hospital errand service might keep the ward staff at the bedside and the pharmacist might be able to help service the medicine closets. It would all add up -- a few more hours every day on every ward to give more care to patients. The first stretch -- nurses for nursing.

CAREFUL ASSIGNMENT

Nursing is not a one-woman job. Nursing care and services include some activities demanding no skill and no judgment and other activities requiring a high degree of manual skill, but of more importance at times, unusual judgmental skills. It is no longer economical or really honest in these days of need to expend the abilities of good professional nurses where they are not needed. Many others can be substituted, if assigned wisely: Practical nurses can be trained on the job, aides, ward secretaries or clerks, ward administrators or administrative assistants and volunteers.

Practical nurses, aides and volunteers usually add nursing hours for patient care. Ward secretaries and administrative assistants free the head nurse of clerical and administrative functions, leaving her time to plan, to teach, to supervise, to work directly with doctors and patients and their families. The clue to the

[illegible]

Sleepers---5

successful use of all of these workers lies in preparing them to do the jobs assigned to them and in the psychological preparation of all other ward personnel to accept them as respected members of the ward staff who will make a significant contribution to patient care. The non-nurse should belong to the staff, and share in the knowing and the planning as well as in the work. So the second stretch is -- nursing is not a one-woman job.

CO-ORDINATED PROGRESS

Together we stand -- the nurse and the nursing personnel. How do nurses learn how to work with all these newcomers to the wards? Who ever saw a real nurse who wanted to turn over much of the patient care to anyone else? How does the non-nurse learn to work with this efficient creature who seems so very much "in the know" with the doctors? How are they both kept up to date, and able to make their maximum contribution?

Industry long ago discovered that people need constant education and re-education in order to grow in proportion to their growing jobs and responsibilities. Every worker in the hospital, too, needs and deserves this same opportunity. In-service education is not a luxury but a necessity. When every worker, nurse and ~~on~~^{by} non-nurse, is prepared for the actual job she is to do, economies in time will follow. If the teaching is co-ordinated, no one worker or group of workers will fall behind; no one will get too far ahead. Co-ordinated progress, then, is the third stretch.

PARTNERSHIP

A bargain package -- partnership and improved administration --

Slip—2

...the job assigned to them and is the biological preparation of
all other ward personnel to accept them as repeated members of the
ward staff who will make a significant contribution to patient care.
The non-nurse should belong to the staff, and share in the planning
and the planning as well as in the work. So the second strategy is
to make it not a one-way job, but a two-way job. It can be done
if the nurse and the non-nurse are both interested in the work.
Now let us turn to the nurse. The nurse and the non-nurse should
do things together. How to work with all these new people to the ward?
Who ever saw a nurse who wanted to turn over much of the job
to the non-nurse? But does the non-nurse learn to work
with this efficient person who is so much more efficient than the
with the doctor? And they both keep up to date and interested.
Make their relationship a good one. Let the non-nurse be the one
to find out what the nurse has discovered that he has had constant education
and re-education in order to grow in proportion to their growing
job and responsibilities. Let the nurse be the one who keeps up to date
and interested. Let the non-nurse be the one who keeps up to date
and interested. When every worker, nurse and non-nurse,
is prepared for the actual job she is to do, secondly the time will
follow. If the learning is co-ordinated, no one worker or group of
workers will fall behind, no one will get too far ahead. Co-ordinated
progress, then, is the third strategy. Let the nurse and the non-nurse
PARTICIPATE in the learning process from the first to the last.
A bargain package -- partnership and improved education --

Sleeper---6

is a must: It is a question of status quo or the acceptance of change, an outmoded organization or an organization in the modern manner.

Industrial management sometimes rewards the good worker by giving him a share in the company's profits. This seems logical since the worker has obviously helped to accumulate these profits. The hospital has no monetary profits to share. If any could be accumulated, they would rightly belong to the patient. But it does have satisfactions, and stimulation, and joys of partnership, all of which the worker at all levels of responsibility could share to a degree and enjoy. All of these add prestige to the job, and to the worker who holds that job.

There are others, too, whom we can admit to partnership to the advantage of all, including the patients, who are the consumers of our nursing services. Since schools of nursing began in the last century, the value of the advisory committee for such schools has been recognized. Why not the same for the nursing service? Surely the doctor, the hospital administrator, the trustee, the citizen would be interested in our nursing service problems. No one more than they should want to understand the nursing situation today. Surely we also could benefit by their knowledge and their ideas. Partnership must be our fourth stretch.

TEAM ORGANIZATION

Organization in the modern manner. Just what should be the organization for the nursing service from 1954 to 1960? Serious

...in the modern manner. Just what should be the
TEAM INDUSTRY? It is not a question of whether the
Partnership must be our fourth strategy. We must
surely we also could benefit by their knowledge and their ideas.
then they should want to understand the nursing situation today.
could be benefited in our nursing service problems. We use more
theories, the new kind of administration, the practice, the clinical
level, the value of the advisory committee for each hospital and
not nursing practice. These schools of nursing began in the last
century, still, including the practice, who are the successors of
the workers, the kind of the kind of the kind of the kind of the
together and enjoy. All of these relationships to the job, and to
of which the workers at all levels of responsibility could share in
have satisfaction, and stimulation, and joy in partnership, all
relationships would naturally belong to the practice. But it does
The hospital has no necessary profit; it should be no
since the worker has obviously helped to demonstrate these qualities.
lying with others in the company's profits. This seems logical and
the worker by the industrial management sometimes within the good worker by

Sleepers—7

study in this area is just beginning. We cannot all do research of this type, but we can all search for methods of organization which are best adapted to the new workers and the new work confronting us. We can all keep open minds, we can try the new.

Much has been written on the team plan, and much has been done in many hospitals to institute the team plan of patient care. Perhaps in some places the method has failed: When application of a method precedes acceptance of the concept behind it, half-hearted success, or even failure, may be the result. The team concept is not only for the bedside care team; its acceptance should begin in the team that plans for the hospital as a whole.

You have without doubt heard of the Joint Commission for the Improvement of the Care of the Patient, in which appointees from the American Hospital Association, the American Medical Association, the American Nurses' Association and the National League for Nursing sit down together to clarify issues and seek understandings. This is one application of the team concept on the national level. This commission has from its beginning in 1948 urged the formation of such groups on the state, the local and the institutional levels; there should be a hospital team, a ward team and a bedside nursing team. Good as our results have been with the team plan, it is possible that the nurses may have gone ahead of some of their teammates in this instance. Forward motion is not truly possible unless the parts of the team are in their proper places.

Administration also includes planning and direction of nur-

October 1947

many in this line is just beginning. We cannot all be teachers of
 this type, but we can all learn for methods of organization which
 are best suited to the new workers and the new work confronting us.
 We can all keep open minds, we can try the new things, and we can
 learn from each other. Much has been written on the team plan, and much has been done
 in many hospitals to institute the team plan of patient care. But
 even in some places the method has failed. When application of a
 method produces acceptance of the concept of the team, the team concept is
 success, or even failure, may be the result. The team concept is
 not only for the bedside care team, its acceptance should begin in
 the team that plans for the hospital as a whole.
 The new concept of the Joint Commission for the
 Improvement of the Care of the Patient, in which specialists from the
 American Hospital Association, the American Medical Association,
 the American Nurses' Association and the National League for Nursing
 sit down together to clarify issues and seek understandings. This
 is one application of the team concept on the national level. This
 organization has from its beginning in 1948 urged the formation of
 such groups on the state, the local and the institutional levels.
 There should be a hospital team, a ward team and a bedside nursing
 team. Good as our results have been with the team plan, it is pos-
 sible that the nurses may have gone ahead of some of their colleagues
 in this instance. Forward motion is not truly possible unless the
 parts of the team are in their proper places.
 Administration also includes planning and direction of nursing

Sleeper---8

sing care. There is too little time for discussion of all the aspects of administration. What does planning mean in your nursing service -- is it just assignment or is it also counseling? Does it mean supplying the locker rooms, the residence, and food service which make contented workers? Is it studying the causes for instability which might drain the energies of the ward staff? Is it planning for and providing equipment and supplies, new buildings and new patient units, which reduce frustrations and make for ease of workmanship? Planning in the modern manner offers not just the fifth stretch, but an unlimited possibility for improvement in nursing service.

PRESSURE OF CHANGE

If we could discover how to get nurses and nursing personnel to evaluate new ideas critically and constructively and to accept those which are sound, the problem of stretching the nurse would be in considerable part solved. But desire for change is no more a part of all people than are blue eyes or red hair. Patients resist it. Doctors are troubled by some of it. Hospital administrators and trustees must worry about costs. Nurses are too often not experiment-minded.

But change must be or the times will pass us by. New ideas are in the wind -- new courses in nursing service administration and work-simplification; new methods of developing better inter-personnel relations; new studies of nursing activities; new materials on training of the non-nurse; and new institutes and publications

Slayer—2

There is too little time for discussion of all the as-
pects of administration. What does planning mean in your nursing
service—is it just assignment or is it also counseling? Does
it mean supplying the locker room, the residence, and food service
which make contented workers? Is it studying the causes for in-
stability which might drain the energies of the staff? Is
it planning for and providing equipment and supplies, new buildings
and new patient units, which reduce friction and make for ease
of workmanship? Planning in the modern manner offers not just the
little stretch, but an unlimited possibility for improvement in
nursing service.

PRESSURE OF CHANGE

It would be discover how to get nurses and nursing personnel
to evaluate new ideas critically and constructively and to accept
those which are good, the problem of stretching the nurse would be
in considerable part solved. But desire for change is no more a
part of all people than are blue eyes or red hair. Patients re-
sist it. Doctors are troubled by some of it. Hospital administra-
tors and trustees must worry about costs. Nurses are too often
not experiment-minded.

But change must be or the times will pass us by. New ideas
are in the wind — new courses in nursing service administration
and work-alphabets; new methods of developing better inter-
personal relations; new studies of nursing activities; new meth-
ods on training of the non-nurse; and new institutes and publications

Sleeper---9

research projects and services. Irresistible change must be our final stretch.

Now we have one nurse who suddenly has become six more nurses. Will all the new plans work together? It was recently written: "The old narrow trails where two cars could barely pass without colliding are being replaced by splendid wide highways where six or eight cars can collide at one time." This need not happen to our six new "stretched" nurses, if we base ~~that~~ our plans upon sound aims derived from a philosophy of nursing service which recognizes the situation and its demands, and the workers and their needs. Surely with such a philosophy we can keep our "avenues" wide enough to allow our six new nurses and the present nurse to march along together and to give each other a helping hand in meeting the patients' needs.

Short dash,-----
fl. left

square,
One 6-pt. ~~tasky~~
fl. right

Miss Sleeper is president of the National League for Nursing.

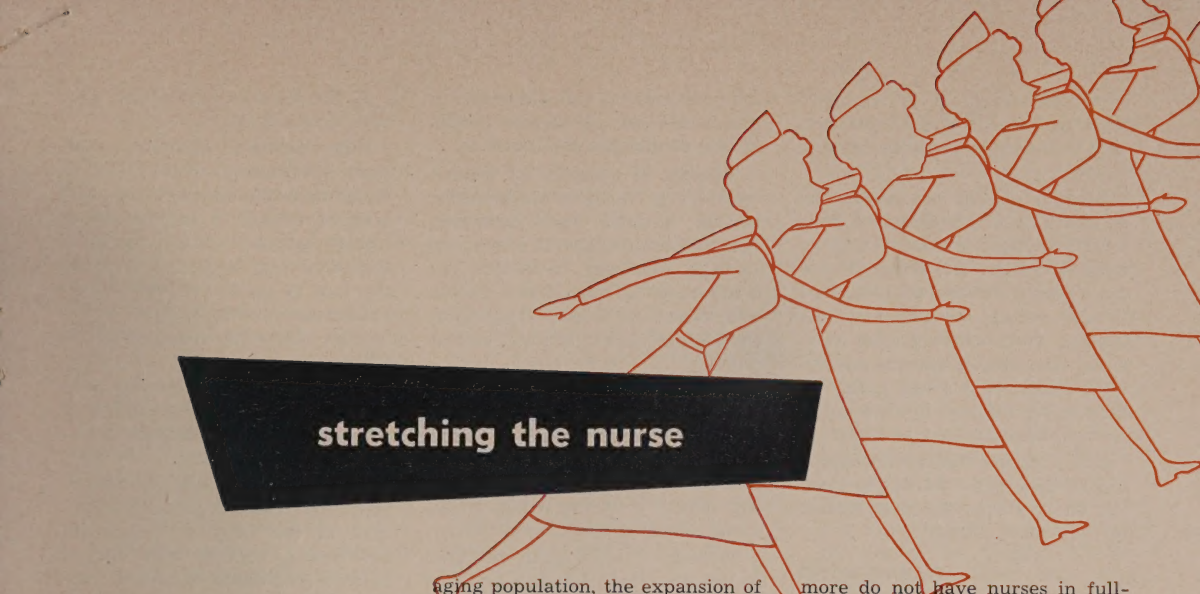
Slipover—9

Research projects and services. Irresistible change must be our
 final solution.
 Now we have one nurse who suddenly has become six more nurses.
 Will all the new plans work together? It was recently written:
 "The old narrow trails where two cars could barely pass without
 colliding are being replaced by highways where six or
 eight cars can collide at one time." This need now applies to our
 six new "stretched" nurses. If we have them all lined up upon sound
 and derived from a philosophy of nursing service which recognizes
 the situation and its demands, and the workers and their needs,
 surely with such a philosophy we can keep our "avenues" wide enough
 to allow our six new nurses and the present ones to march along
 together and to give each other a helping hand in meeting the

Slipover, needs.
 One 6-95. 11. right

Short dash
 11. left

Miss Slipp is president of the National League for Nursing.



stretching the nurse

RUTH SLEEPER, R.N.

STRETCHING THE nurse—it sounds so intriguing. What possibilities, if we could actually transform one precious staff nurse into two, or three, or even more. My thoughts jump to the paper cut-outs of my childhood, where with paper properly folded, the scissors traced the shape of one child. Then immediately the paper opened and there were five or even ten children, holding hands and marching along together.

Could we, perhaps, visualize some way to stretch a nurse which would produce a whole chain of new nurses? Perhaps it would be miracle enough if we could set up a chain of events so that many people, some of them nurses, might march along together to meet the demands that nurses alone could not meet. How good it would be, after all these years of pressures and apologies, to be able to have a positive answer for hospital administrators and doctors; and especially for patients.

NURSING SHORTAGES

We have repeated the causes for our inadequate numbers over and over; the growing population, the

aging population, the expansion of voluntary health insurance, increased use of hospital beds, the building of more hospitals, advances in medical science, the extension of public health service and the needs of the military. It has seemed, sometimes, as if this recitation of the causes of our shortage might help to excuse our inability to stem the tide of demand.

But we could not forget the other side of the picture. Too often, regardless of the soundness of our reasoning, we have felt a sense of blame. In spite of the fact that almost half of the country's 334,733 professional nurses are employed in hospitals, patients in some hospitals had inadequate care. General hospitals throughout the country average one nurse to every three patients, a deceiving figure indeed—some hospitals with special services and schools have better than one to three and other hospitals have too few professional nurses to give the needed care or even to give proper supervision to auxiliary workers, whose preparation varies from adequate to none at all. Then there are the mental hospitals, with an average of one nurse to 13 patients. We must face the fact that some hospitals have only one nurse to several hundred. And in all hospitals, the patients' chances for recovery depend in part upon their nursing care.

The public health picture is brighter in many communities. We are told that only 13 incorporated cities with populations of 10,000 or

more do not have nurses in full-time public health work. But many people live in smaller communities, and rural areas, who still lack this valued service. The public health nurse must begin where the hospital nurse leaves off; and in these days of earlier discharges, she will carry a part of the nursing care formerly given by the hospital nurse.

ANSWERS NEEDED

You know all this. You, as I, have doubtless recited the list many times. You have finally faced the situation and admitted to yourself that there will not be enough professional nurses, at least for years to come. So, other ways must be found to meet the obligations which rightly fall upon us.

We must stretch our nursing to encompass our obligations, but we cannot stretch a vacuum. Recruitment must continue. *Better and more recruitment of students for nursing and students for practical nursing is needed.* We need have no cause for embarrassment: In these years when fewer girls are of an age to graduate from high schools our national recruitment has surpassed that of the prewar years. More nurses are practicing nursing than ever before. Over half of these practicing nurses are married. Active state league committees on recruitment, and others, will help to produce more graduate nurses in 1957, provided the students find satisfaction in good schools with programs which stimulate and hold interest. Constant

Miss Sleeper is president of the National League for Nursing and director of the School of Nursing and Nursing Service at Massachusetts General Hospital in Boston.

edge effectively. It is not how much you know that counts, but how well you put your knowledge to use.

Finally, we must consider the approach to the problem of personnel friction. We must act, we must do things; and above all, we must keep a positive attitude. You should reflect cheerfulness, optimism, understanding and initiative: You can change and control the attitude of a whole group by looking for the best in others, and by having a tolerant attitude.

But what are the specific ingredients that will add up to good human relations, the prescription for personnel friction?

VITAMINS NOTED

As we know, there has been tremendous advancement in medicine and hospital work in the last few years: One of the important advances has been knowledge of vitamins. As our knowledge grows, their importance becomes greater and greater. We have found that vitamins are necessary for the normal processes of body metabolism, and that their absence results in a deficiency disease—hypovitaminosis.

As vitamins are essential nutrients and must be supplied to keep the human body functioning properly, so, too, the vitamins of human relations must be supplied to keep the hospital body working smoothly. A lack of human relations "vitamins" will result in deficiency diseases also, such as reduced production, friction and lowered morale. We know much about the vitamins we use in medicine, but what about the human relations vitamins? Let us examine them and their effects upon personnel relationships.

Vitamin A in the human body is related to growth, nutrition, sight and resistance to infection.

Vitamin A of human relations is *PATIENCE*. It prevents friction, promotes the growth of morale and personal insight, and resists the infection of thoughtless words and deeds.

Vitamin B, in medicine, has been found to be a combination of many factors, rather than one vitamin. This group of factors is called *Vitamin B complex*, and is neces-

sary for normal human nutrition and well-being. Its absence results in loss of appetite and vigor.

Vitamin B complex of human relations is *CHARITY*. Its presence in the hospital body nourishes normal relationships. It stimulates friendly relations, promotes the brotherhood of man, raises morale and makes for happy employees, something which money cannot buy.

Vitamin C in the body is directly concerned with the oxidation-reduction reaction of all living cells. It is also concerned with the formation of collagen, the supporting structure of the bones, teeth, blood vessels and red blood cells.

Vitamin C of human relations is *JUSTICE*. This vitamin is a virtue that inclines us to give every man what belongs to him. It is an essential element in all the activities of the hospital. It brings about truthfulness, proper respect for others, helpfulness, gratitude, and fosters the formation of good relationships—the supporting structure of the hospital body. In medicine, *vitamin C* is very frequently given in combination with other vitamins after a surgical operation, to promote healing and thus hasten recovery. So, too, in human relations, this vitamin administered along with the other vitamins of human relations promotes the healing of injury and hastens recovery.

Vitamin D in the body is essential to bone growth and tooth development. It is an absolute necessity if we are to develop strong, healthy bones and become strong, healthy individuals.

In human relations, *vitamin D* is *UNDERSTANDING*. This is so important in personnel relationships that without it these relationships are strained, undesirable and unhappy. Strong, healthy personnel associations cannot exist without understanding.

Vitamin E, in medicine, is thought to be of value in preventing sterility.

In human relations, *vitamin E* is *CHEERFULNESS*. It creates pleasure, inspires truthfulness and stimulates confidence; and it dispels the sterile atmosphere of depression, unhappiness and lethargy which might result from lowered morale.

In life, *vitamin K* is used to prevent hemorrhage.

The *vitamin K* of human relations is *PRUDENCE*, which helps us on all occasions to judge the right way of acting. It enables us to rightly interpret directions, rules and advice, as well; and prevents the loss of good relations due to negligence, inconsideration, indifference, instability and precipitate action.

Vitamin P in the human body has to do with the permeability of the capillaries: Deficiencies result in hypoproteinemia.

Vitamin P in human relations is *THOUGHTFULNESS*. It prevents weakness in the hospital body, and counteracts friction and lowered morale: The bonds of careful consideration are kept sufficiently elastic to meet the changing needs of personnel relationships.

Use the vitamins of human relations generously each day, and I can assure you that your personnel hypertension will be greatly reduced. We need not worry about an overdosage: In using human relations vitamins, that is impossible. People are not allergic to these vitamins.

OTHER FACTORS

You know, of course, that vitamin pills are not a substitute for all the essentials of life. Important as vitamins are, they are only a part of the nutrition picture in the human body. In the hospital body, the vitamins of human relations are only a part of the factors essential for a healthy relationship of all personnel and all departments.

We are unable to avoid inter-departmental relationships in the modern hospital because one department cannot give complete and adequate care. That this relationship must be good cannot be over-emphasized. There must be teamwork if the hospital is to function smoothly and efficiently: When people work well together, they do a better job. When personnel in the various departments understand each others' functions, everyone benefits. They all become proud together.

To secure this desired relationship between personnel and de-
(Continued on page 181)

study of school programs by the school faculties, the use of accreditation and consultation services of the National League for Nursing can help to develop schools which attract applicants and retain students. This is our bank account for the future—more and better recruiting.

The times now demand that we employ and assign *nurses for nursing*. This is not a new idea. Neither has this idea been completely accepted, although it is often repeated. How many hours might be gained if all housekeeping activities were transferred to the housekeeping department? How many more would be saved if the dietary department assumed full responsibility for the patients' tray service, or if the hospital operated a central supply room which completely serviced the wards? On large floors, what would it mean in patient care time if an aide serviced the utility rooms and all of the equipment? A hospital errand service might keep the ward staff at the bedside and the pharmacist might be able to help service the medicine closets. It would all add up—a few more hours every day on every ward to give more care to patients. The first stretch—nurses for nursing.

CAREFUL ASSIGNMENT

Nursing is not a one-woman job. Nursing care and services include some activities demanding no skill and no judgment; and other activities requiring a high degree of manual skill, but of more importance at times, experience and judgment. It is no longer economical or really honest in these days of need to expend the abilities of good professional nurses where they are not needed. Many others can be substituted, if assigned wisely: Practical nurses can be trained on the job, aides, ward secretaries or clerks, ward administrators or administrative assistants and volunteers.

Practical nurses, aides and volunteers usually add nursing hours for patient care. Ward secretaries and administrative assistants free the head nurse of clerical and administrative functions, leaving her time to plan, to teach, to supervise, to work directly with doctors

and patients and their families. The clue to the successful use of all of these workers lies in preparing them to do the jobs assigned to them and in the psychological preparation of all other ward personnel to accept them as respected members of the ward staff who will make a significant contribution to patient care. The non-nurse should belong to the staff, and share in the knowing and the planning as well as in the work. So the second stretch is—nursing is not a one-woman job.

CO-ORDINATED PROGRESS

Together we stand—the nurse and the nursing personnel. How do nurses learn how to work with all these newcomers to the wards? Who ever saw a real nurse who wanted to turn over much of the patient care to anyone else! How does the non-nurse learn to work with this efficient creature who seems so very much "in the know" with the doctors? How are they both kept up to date, and able to make their maximum contribution?

Industry long ago discovered that people need constant education and re-education in order to grow in proportion to their growing jobs and responsibilities. Every worker in the hospital, too, needs and deserves this same opportunity. In-service education is not a luxury but a necessity. When every worker, nurse and non-nurse, is prepared for the actual job she is to do, economies in time will follow. If the teaching is co-ordinated, no one worker or group of workers will fall behind; no one will get too far ahead. Co-ordinated progress, then, is the third stretch.

PARTNERSHIP

A bargain package—*partnership and improved administration*—is a must: It is a question of status quo or the acceptance of change, an outmoded organization or an organization in the modern manner.

Industrial management sometimes rewards the good worker by giving him a share in the company's profits. This seems logical since the worker has obviously helped to accumulate these profits. The hospital has no monetary profits to share. If any could be

accumulated, they would rightly belong to the patient. But it does have satisfactions, and stimulation, and joys of partnership, all of which the worker at all levels of responsibility could share to a degree and enjoy. All of these add prestige to the job, and to the worker who holds that job.

There are others, too, whom we can admit to partnership to the advantage of all, including the patients, who are the consumers of our nursing services. Since schools of nursing began in the last century, the value of the advisory committee for such schools has been recognized. Why not the same for the nursing service? Surely the doctor, the hospital administrator, the trustee, the citizen would be interested in our nursing service problems. No one more than they should want to understand the nursing situation today. Surely we also could benefit by their knowledge and their ideas. Partnership must be our fourth stretch.

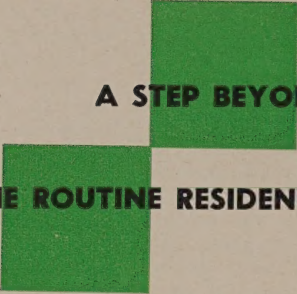
TEAM ORGANIZATION

Organization in the modern manner. Just what should be the organization for the nursing service from 1954 to 1960? Serious study in this area is just beginning. We cannot all do research of this type, but we can all search for methods or organization which are best adapted to the new workers and the new work confronting us. We can all keep open minds, we can try the new.

Much has been written on the team plan, and much has been done in many hospitals to institute the team plan of patient care. Perhaps in some places the method has failed: When application of a method precedes acceptance of the concept behind it, half-hearted success, or even failure, may be the result. The team concept is not only for the bedside care team; its acceptance should begin in the team that plans for the hospital as a whole.

You have without doubt heard of the Joint Commission for the Improvement of the Care of the Patient, in which appointees from the American Hospital Association, the American Medical Association,

(Continued on page 184)



A STEP BEYOND THE ROUTINE RESIDENCY

BANKS I. PAUL

ATTEendance at medical and administrative staff conferences has long been recognized as essential in the training of hospital administrative residents. The Veterans Administration Hospital in Brooklyn has gone a step beyond this. In its training program, it stresses the importance of developing conference techniques as a valuable tool to the administrator: The resident is required to plan, develop and lead a conference during his course of training.

Group discussions represent an important phase in the academic work of the administrative student. Doctors in their course of training have many conferences; they not only exchange information, ideas and opinions, but at the same time develop group discussion techniques. There is rarely more than one administrative resident in a single hospital, however, and this places the student at a disadvantage, unless arrangements are made for him to meet in discussion with administrative

residents from other hospitals.

In the greater New York area, it was found that there were at least ten administrative residents within easy commuting distance of the Brooklyn Veterans Administration Hospital. The administrative resident undertook to plan and to conduct such a conference.

Invitations were written to each area resident, asking suggestions for the agenda. It was decided to build the program around the activities of one major hospital division rather than to spread it thinly over several. The Registrar Division—the division that groups together many of the medical administrative functions in any Veterans Administration hospital—was selected. This division is divided into two main sections: The patient control section, which is made up of the admitting, eligibility, statistical, correspondence and follow-up units; and the ward administration section, which consists of the ward secretary, the dictaphone pool, ward property and supply, and patient's clothing and valuables units. Since all hospitals have in their organization these units in some form, there

could be unlimited discussion about either section.

The residents agreed on the suggested agenda and plans were immediately made to develop the program. Panelists were engaged and arrangements made with the dietitian for lunch; the information service had to know whom the guests were to be; and the cooperation of the workshop and other areas to be visited was sought.

ONE DAY MEETING

The conference itself occupied one full day. In the morning session, after the opening remarks, the organization and administration of the hospital was described, and activities of the Registrar Division tied in with the over-all operation. The conferees attended a professional staff-meeting, following which the chief of professional services made himself available for questions.

The afternoon session was in the form of a workshop in the Registrar Division. Conferees traced the progress of a patient from admission through to the ward, and studied the duties of the ward secretary. Following a visit to some of the clinical areas, the group returned to the conference room for an evaluation of the day.

FUTURE SESSIONS

Interest in the conference was shown by the excellent attendance. It was agreed by the group that they had not only been enlightened about this particular program of hospitalization, but that the meeting had stimulated new ideas. The value of planning and conducting such a project as a means of developing conference techniques was discussed. Responses expressing interest in future conferences have been received, and the planning of a similar conference by another resident is now underway.

The New York area is fortunate in having so many of the residents readily available for these conferences, but it is apparent that even the meeting of two hospital administrative residents in a less populated section would provide a starting point for a stimulating exchange of ideas. ■

Mr. Paul is administrative assistant of the Veterans Administration Hospital in Brooklyn.

practicable in regard to the physical plant.

Careful screening of applicants is one of the basic prescriptions for preventing personnel friction. Persons should not be hired who are not right for the job. Good organization also requires that sufficient thought be given to placement of the worker in the department: The assignment should be sufficiently stimulating to make the employee a satisfied worker.

An adequate orientation program for the new employee is essential to establish rapport. It gives him insight into the institution, establishes the feeling of belonging and prevents others from slighting him.

Two especially valuable prescriptions to use in securing enthusiastic day-in and day-out response from workers are common sense and courtesy. You cannot buy enthusiasm, initiative, loyalty and devotion. An administrator can get no more effective performance, however, than he is able to deliver personally. The

way he does his own work is an inspiration to everyone else. Subordinates tend to "glorify the boss" and make him a symbol of the organization: He must live up to this symbol at all times, because his example will be followed by his personnel.

As administrators and supervisors, you must be democratic and friendly to all employees, and avoid playing favorites. Never consider any of the duties of your department beneath your dignity as a department head: This is often one of the chief causes of friction. A keen sense of humor, an important asset in any type of human relations, will carry you through many a rough spot. Criticisms of an employee or another department should be made in private, with tact, and in a constructive manner.

Have an open mind to suggestions, complaints and criticisms. Remember that others, as a rule, are better judges of our service than we are. We should make it possible to talk things over in

conference with individuals and department heads, and to iron out the difficulties that may arise. We must avoid the mechanical, impersonal, uncooperative and "too busy" attitudes: They cause unnumbered frictions.

We will get better service by being kind and courteous, rather than by being rude and disagreeable. In meeting the problem of personnel hypertension, something more than reason and knowledge is needed: If we are to act wisely, we must also listen to the counsel of the heart.

Bearing all this in mind, in conclusion, we must remember that we are going to have human relations anyway, so they might as well be good. If they are good, it will make our job easier, as well as far pleasanter. It will give us satisfaction, happiness and peace of heart that money cannot buy.

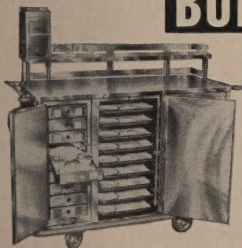
The one great principle, of most benefit in securing good human relations and in preventing friction, is the Golden Rule: "Do unto others as you would have them do unto you."

You don't have to do
this to serve
TEMPERATURE-RIGHT
meals



Meals-on-Wheels

BUILT FOR THE JOB



Model 18-D-1 Hot-N'-Cold Cart. Stainless steel; 61" long; 27" wide; counter 43" high; service shelf 6 1/2" above counter provides for 3 hot or cold beverage containers. Cart takes trays 14"x18" up to 16"x22".

Meals-On-Wheels... the only central tray service that separates hot and cold foods logically... preserves the crispy coldness of cold foods — the piping hot goodness of hot foods.

The tray, cold foods and all accessories are carried logically in the cold compartment. Only the few foods meant to be hot are placed in the electric oven.

Don't let time and distance rob perfection from well-prepared meals. Let us show you how Meals-On-Wheels effectively bridges the gap between kitchen and patient. It's built for the job.

WRITE FOR INFORMATION TO



1734 OAK — KANSAS CITY, MO.

Stretching the nurse (Continued from page 81)

the American Nurses' Association and the National League for Nursing sit down together to clarify issues and seek understandings. This is one application of the team concept on the national level. This commission has from its beginning in 1948 urged the formation of such groups on the state, the local and the institutional levels; there should be a hospital team, a ward team and a bedside nursing team. Good as our results have been with the team plan, it is possible that the nurses may have gone ahead of some of their teammates in this instance. Forward motion is not truly possible unless the parts of the team are in their proper places.

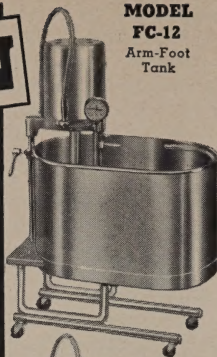
Administration also includes planning and direction of nursing care. There is too little time for discussion of all the aspects of administration. What does planning mean in your nursing service—is it just assignment or is it also counseling? Does it mean supply-

DAKON

STAINLESS STEEL WHIRLPOOL BATHS

**QUIET...DEPENDABLE
MAINTENANCE FREE..**

DAKON silent-running Whirlpool Baths are used in over 6000 institutions. They combine—in a single mechanism—an efficient electric turbine ejector, aerator and drainage system. A half-turn of the patented DAKON valve converts turbine operation to drainage operation. Durable construction, permanent lubrication keep maintenance to a minimum. DAKON units available in a full range of models for stationary or mobile use.



**MODEL
FC-12**
Arm-Foot
Tank



**MODEL
F-12**
Foot-Tank



Send today for Catalog #1-50

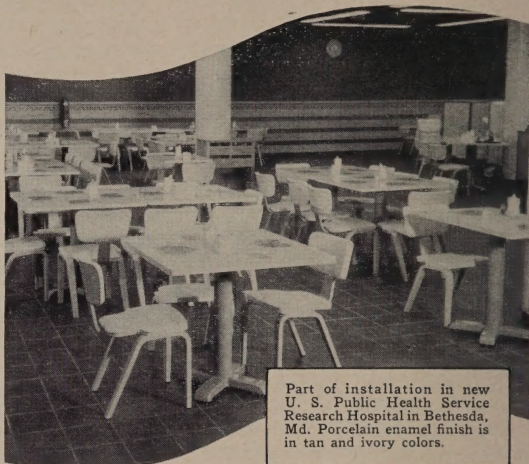
DAKON TOOL & MACHINE CO., INC.
496 Broadway • Brooklyn 11, N. Y.

West Coast Representative: Roland J. Gaupel Company
1014 North La Brea Avenue, Los Angeles 38, California

261 TABLE BASES

in lifetime
porcelain enamel

New U. S. Public Health Service Hospital Chooses
3 Styles and 2 Color Combinations



Part of installation in new
U. S. Public Health Service
Research Hospital in Bethesda,
Md. Porcelain enamel finish is
in tan and ivory colors.

"CHF" offers you the Largest Selection Of Stools and Tables Anywhere!

New Designs . . . New Comfort . . . New Colors!

You can be sure your installation will be "color-right" and "style-right" when you choose from the wide range of new styles, colors, and finishes available in "CHF" stools and tables. Lifetime porcelain enamel in 11 colors . . . luxurious solid bronze . . . mirror plated finishes . . . anodized aluminum . . . all are designed for easy maintenance and long service. Cast construction assures the rugged dependability needed for public food service. You know you're right when you choose "CHF" because, year after year this fine equipment appears in top award winning installations all over the country.



See complete
line of "CHF"
stools for
snack bars
and soda
fountains,
shown in
catalog.

"CHF" SECTIONAL TABLES WITH SWING SEATS
... the universal table for industrial and institutional cafeterias . . . exclusive with The Chicago Hardware Foundry Co.

SANI-DRI ELECTRIC HAND DRYERS

—the original dryers to eliminate towel costs and cut down needless maintenance and overhead.

**WRITE TODAY FOR NEW
ILLUSTRATED COLOR CATALOG**
Shows complete line of "CHF"
stools and tables in full color, plus
many installation ideas.



Distributors in Principal Cities

THE CHICAGO HARDWARE FOUNDRY CO.

"Dependable Since 1897"

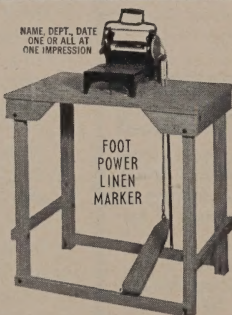
3534 Commonwealth Ave. • North Chicago, Ill.

UNSORTED? STOLEN? LOST? AVOID LINEN LOSSES!

with the Applegate System

Use the Applegate marker
... The Only inexpensive
marker that permits the
operator to use both hands
to hold the goods and mark
them any place desired.

NAME, DEPT., DATE
ONE OR ALL AT
ONE IMPRESSION



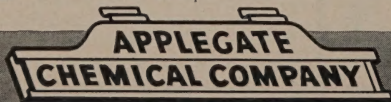
FOOT
POWER
LINEN
MARKER



USE APPLAGATE INKS

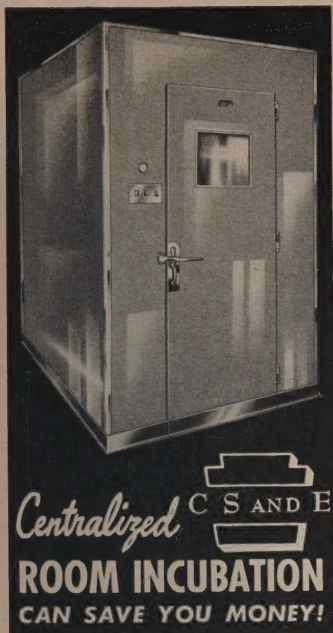
Applegate indelible (silver base) ink is everlasting . . . heat permanizes your impression for the life of the cloth, contains no aniline dye.

Xanno indelible ink is long lasting . . . does not require heat.



5632 HARPER AVE.

CHICAGO 37, ILL.



Easiest to Clean and Keep Clean

Centralized incubation, the most modern, safe method of volume incubations, was pioneered by C.S. and E. 35 years ago and has been accepted as the standard throughout the world. Today many large hospitals, V.A. hospitals, and others have adopted this method as the lowest cost, most practical and most efficient method of maintaining, growing and testing cultures.

Outstanding C. S. & E. room incubator features are smooth interiors and elimination of hard-to-clean ducts and dirt-catching louvers or chambers. Other exclusive features are:

- ✓ Aluminum Exterior and Interior
- ✓ Heavy 3" Glass Wool Insulation
- ✓ Exclusive Dual Control Adjustable Thermostats
- ✓ Rubber Cove Moulding
- ✓ Perforated Aluminum Shelves
- ✓ Fully Enclosed Thermoplate Heaters—All interior duct work eliminated
- ✓ Plenum Chamber Circulating System No interior duct work
- ✓ Circular Fluorescent Lighting
- ✓ Heavy Aluminum Floor Plate

4 SIZES AVAILABLE

from Jr. Room Model (3' w. x 2' d. x 6½' h.) to Large Room Model (4' w. x 8' d. x 7' h.)

Write for Cat. 100H. Sec. 2.

CHICAGO SURGICAL and ELECTRICAL COMPANY

DIVISION OF LABLINE, INC.
217 N. Desplaines St., Chicago 6, Ill.

ing the locker rooms, the residence and food service which make contented workers? Is it studying the causes for instability which might drain the energies of the ward staff? Is it planning for and providing equipment and supplies, new buildings and new patient units, which reduce frustrations and make for ease of workmanship? Planning in the modern manner offers not just the fifth stretch, but an unlimited possibility for improvement in nursing service.

PRESSURE OF CHANGE

If we could discover how to get nurses and nursing personnel to evaluate new ideas critically and constructively and to accept those which are sound, the problem of stretching the nurse would be in considerable part solved. But desire for change is no more a part of all people than are blue eyes or red hair. Patients resist it. Doctors are troubled by some of it. Hospital administrators and trustees must worry about costs. Nurses are too often not experiment-minded.

But change must be or the times will pass us by. New ideas are in the wind—new courses in nursing service administration and work-simplification; new methods of developing better inter-personnel relations; new studies of nursing activities; new materials on training of the non-nurse; and new institutes and publications, research projects and services. Irresistible change must be our final stretch.

Now we have one nurse who suddenly has become six more nurses. Will all the new plans work together? It was recently written: "The old narrow trails where two cars could barely pass without colliding are being replaced by splendid wide highways where six or eight cars can collide at one time." This need not happen to our six new "stretched" nurses, if we base our plans upon sound aims derived from a philosophy of nursing service which recognizes the situation and its demands, and the workers and their needs. Surely with such a philosophy we can keep our "avenues" wide enough to allow our six new nurses and the present nurse to march along together and to give each other a helping hand in meeting the patients' needs. ■

Opinions

(Continued from page 26)

programs are to be conducted. In order that these objectives may be realized, the head nurse would need to have the following information:

Physical, emotional, social, religious, and intellectual needs of each patient.

Over-all plan for coordinating the resources of each department of the hospital, community facilities, the family, and the patient to meet these needs.

Details of the responsibilities of the nursing department in relation to these individualized plans.

Goals and purposes of the teaching and research programs as well as the specific activities for which the head nurse and her staff are responsible. Strengths and weaknesses of each member of the nursing staff.

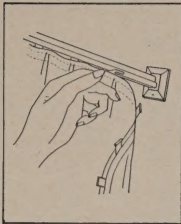
Relationships between staff members and patients.

Under such conditions, the most appropriate size for the nursing unit would be 25 beds. In less complicated situations, the size might safely range to 35 beds.—DOROTHY HASKINS, R.N., student at the University of Chicago and future director of nursing at the new Parkland Hospital, Dallas, Texas.

Hospital association meetings

(Continued from page 6)

- Institute on Public Relations—July 6-9; Princeton, N. J. (Westminster College).
- Institute on Nursing Service Administration—October 18-22; Atlanta, Ga. (Ainsley Hotel).
- Institute on Hospital Purchasing—October 18-22; Chicago (Knickerbocker).
- Institute on Personnel Administration—November 1-5; New York (Statler).
- Institute on Dietetics—November 8-12; Chicago (Sheraton).
- Institute on Nursing Service Administration—November 1-5; Vancouver (Vancouver).
- Institute for Operating Room Supervisors—December 1-3; Omaha (Blackstone).
- Institute on Hospital Laundry—November 29-December 3; Chicago (Knickerbocker).
- Institute on Medical Records—November 29-December 3; Los Angeles (Statler).
- Institute on Hospital Law—December 13-17; Chicago (Knickerbocker).
- Institute on Housekeeping—December 6-10; Los Angeles (Statler).



*Patented

This new Slider Tape*
sewed on curtain



**JOINS
in a
JIFFY**

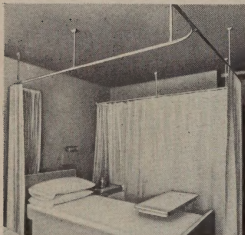
with "Flowing Action"
Curtain Track*

SILENT

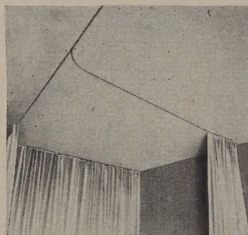
curtain track

**FOR CUBICLES
AND X-RAY
ROOMS**

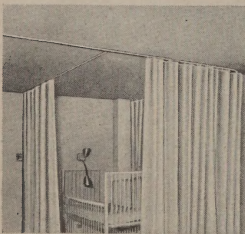
... proved in many of nation's foremost hospitals...praised by staffs, physicians and patients. Economic, easy to install in existing rooms or new construction. Here you see Jiffy Join "Flowing Action" Track...



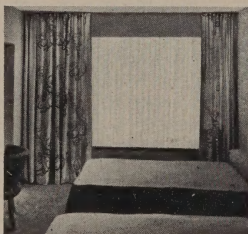
Suspended from ceiling



Recessed in ceiling



Surface-mounted on ceiling



Installed in windows

**FOR ALL KINDS
OF WINDOW,
CURTAIN AND
DRAPERY
TREATMENTS**

With or without pull cords... fabrics "flow" open and close in utter silence... hang securely, beautifully without sagging. No hooks, no rods, no pins. Easy as abc to take down and put up after cleaning.

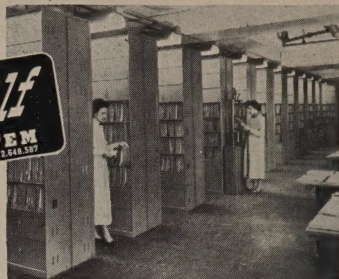
Easy to Specify: Jiffy Join track is non-corrosive extruded aluminum or wood. *Specify by Catalogue Style No.* *Easily Installed* by any carpenter or handy man. *Easy to Order:* Quotations promptly submitted from your sketches or blue prints.

JIFFY JOIN, INC.
153 West 23rd St.
New York 11, N. Y.
•
217 South
Robertson Blvd.
Beverly Hills, Cal.

SAVES up to 60% of FLOOR SPACE!



for
**MEDICAL CHARTS
and
X-RAY NEGATIVES**



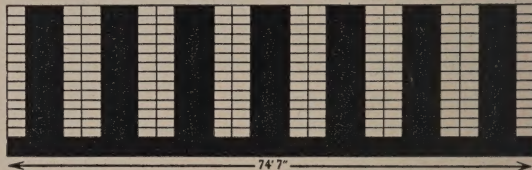
PLANNED

- to "File Twice As Many Records in the Same Space"

TODAY

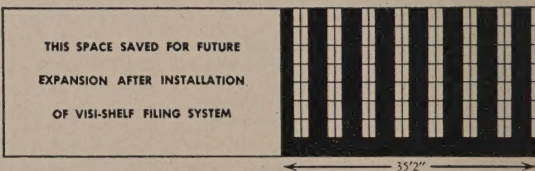
- to meet the challenge of growth
TOMORROW!

FLOOR PLAN OF AN ACTUAL RECORD ROOM BEFORE
INSTALLATION OF THE VISI-SHELF FILING SYSTEM



196 five drawer conventional filing cabinets containing 980 drawers or 24,500 filing inches.

FLOOR PLAN AFTER INSTALLATION OF THE VISI-SHELF
FILING SYSTEM



105 nine-compartment Visi-Shelf Filing Cabinets with a filing capacity of 26,460 filing inches hold all and more records in *half* the floor space!

The Visi-Shelf Filing System is the answer to:

- Increased filing facilities!
- Improved Record Room efficiency!
- Greater Record Accessibility!

Our engineers will gladly assist you (or work with your architects) in planning your present record record department, or proposed record room in the event of new construction, to accommodate the Visi-Shelf Filing System.

For Free Illustrated Brochure and Complete details write:

VISI-SHELF FILE INC.
105 CHAMBERS STREET • NEW YORK 7, N. Y.

EDUCATING FOR PATIENT CARE

Two questions come immediately to my mind as I look at this topic.

What is patient care? As used for the Hospital Nursing School, or as it should be used for any school, what is education?

Risking duplication with Miss Lambertsen, I must consider first what patient care is today, and what it will become when the new trends are felt. Before I continue with this consideration, however, I must call to your attention that patient care in the hospital includes only one segment of the functions assigned to the nurse. She must, with rare exceptions, divide her time between direct patient care and a multitude of other activities. Some of these are completely unrelated to the actual patient care, such as business services, some are concerned with the maintenance of a suitably equipped environment, such as cleaning, some are carried on in order that the doctor, the social worker, the dietitian, the laboratory technicians and others may perform their designated functions. These functions we speak of as "Nursing Service." I do not include them in this discussion of educating for patient care, yet students in nursing often perform all of these functions, sometimes to the detriment of patient care, sometimes therefore to the detriment of the objective which sends her to the patient's unit, that is, to learn to give patient care.

Patient care of course includes the activities performed by all members of the medical team, including nursing, medical, social service, dietary, occupational and physical therapy, laboratory, and many others which

you will add yourself. For this discussion I am separating nursing care from the broad program of patient care.

No one has yet written a definition of nursing care which can satisfy us all. Today I have chosen Virginia Henderson's definition given in her Textbook of the Principles and Practice of Nursing¹, because this definition expresses so well my beliefs. "Nursing is primarily assisting the individual (sick or well) in the performance of those activities contributing to health, or its recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. It is likewise the unique contribution of nursing to help the individual to be independent of such assistance as soon as possible."

You will see that this definition does not include many of the services assigned to nurses, for they are not nursing; e.g. housekeeping, and the like. You will see the nurse as part of a team assisting the other members as they assist her. You will, I trust, also see that in the patient care situation, as in any well organized situation, there must be a balance of contribution made by each member, and a control which prevents one member of the team from shifting the load so as to prevent another member from performing at the highest possible level in his own sphere.

What does this definition give us to guide our discussion? 1) It places the patient as the central figure; the hospital exists for the care of the patient, and all persons contributing toward this care are educated, or employed and trained on the job, to make their special contribution. 2) It defines the scope of the patient care to be given by the nurse; that is "Helping the patient with his daily pattern of living, or with those activities that he ordinarily performs without assistance; breathing, eating, eliminating, resting,

¹ The MacMillan Company, New York, 1955

must
not pay
we shall not
do our share
as described by
Miss L. - but
how make
supply

sleeping and moving, cleaning the body and keeping it adequately clothed. She also helps to provide for those activities that make life more than a vegetable process: namely, social intercourse, learning, occupations that are recreational, and those that are productive in some way. In other words, she helps him to maintain or create a health regimen that were he strong, knowing, and filled with the love of life he would carry out unaided."¹ In addition to this function which is uniquely that of the nurse, she also helps the patient to carry out the doctor's orders, a program he either could not, or would not do without some one to act for him. May I emphasize that this again is nursing care of the patient and not nursing service. This is an identification of the nurse primarily with the patient and secondarily with the doctor and other members of the medical team. This excludes desk work, except records related to the patient's care. This excludes cleaning of utility rooms, making and sterilizing supplies, etc. I make this emphasis for two reasons. First, I believe nursing of the future will demand that nursing hours be used for nursing care. Second, the continuing need for nurses will not permit wastage of nurses' time for non-nursing functions. This means a reorganization of both administrative activities and functions as presently designated for nurses. It may also mean increased hospital costs. Perhaps even more difficult to achieve, it involves a change in the role of the nurse today, a change for which she has not been prepared, and may not be ready or willing to accept. Finally, it involves a change in the education of the student nurse, and in the education of the instructors who participate in her programs. This, too, will cost money. This, too, will take time. This, too, will need new understandings on the part of hospital administrators who have come to accept the nurse, and sometimes the student nurse, as a hospital worker, not as a substitute for what the patient lacks to become well and independent. It will require new understandings by the doctor who sees

Not mean - will
leave under-
but not part of
nurs. ed -
If nec - stop
ed in grad
Attitude will

¹ Harmer and Henderson, Textbook of Principles and Practice of Nursing
The MacMillan Company, New York 1955

the nurse primarily as his assistant, not as having a primary function which is uniquely hers in the patient's care and recovery.

My discussion today must be limited to the education of the student in nursing to give patient care. Let us first for purposes of clarity consider types of control now operating nursing schools. We have public and private schools, we have hospitals and educational institutions. With them all we continue to graduate fewer nurses than the people of the country need, or will need in the foreseeable future. We have three-year diploma schools, two-year associate degree schools, four- five- and six-year baccalaureate degree or collegiate programs. Who shall say which is best, or which shall continue? Is it not true that any school which can graduate well-prepared nurses to meet the patients' needs, to work effectively with other members of the medical or health team to bring complete care to the people, sick or well, is the right school? If the hospital school can meet the need it is right. If the junior college can meet the need it is right. If the four-, five- and six-year schools can do it they, too, are right. In short the only answer is to be found in the product. Every school issuing a diploma or a degree in basic nursing must prove itself. It is not the diploma or the degree which makes the nurse. It is the sum total of all her learnings which determines whether she can and will meet the patients' needs, and work positively and progressively with the medical or health team. Different demands will be made by different patients, by different medical teams, and by different health programs. Different types of programs may meet the varying demands. We need numbers of nurses, yes. But only the nurse rightly prepared can fill the need completely. Let us remember that the school of nursing prepares practitioners not for the sake of the nurses, but for the care

of patients. It makes no difference to the patient whether his nurse has a diploma or some kind of a degree, provided she can give the necessary care, and have the right personal attributes and attitudes. The patient cared for by a diploma school graduate has the same right, however, to the help necessary to adjust to his permanent colostomy, and in spite of it to hold a job, to live as happily as does the patient whose nurse has a degree. The diabetic, the cardiac, the tubercular patient going home deserves to have preparation for care at home without regard to the education of his nurse or of his head nurse.

We have spent too long in nursing and in hospital circles worrying about the length of our programs. We have been too slow to see that there is one basic criterion for curriculum planning, and one final measure for the achievement of the graduate. That is the patient and his care. All schools of nursing should be able to meet this criterion. Any school which sends out a graduate unprepared in terms of the patients' adjustments in the medical program of 1959 multiplies the problems of nursing and nursing education for the future, and continues to confuse both nurses and the public as to the role the nurse is to play. I might add here that the hospital which does not use its nurses for nursing also adds to this problem.

Education is a much abused word. Cliches warp its meaning. Educators in all fields use it in their own way to further their own fads. If we follow a practical dictionary definition we find it to mean "The training of the mental and moral powers either by a system of study and discipline, or by the experiences of life." In the early days of education for nursing the student nurse's experience was her curriculum. Although there have been many modifications, you and I both know that many student nurses today still have too much unstructured experience, and so their learning processes are slow and expensive. Such a system can no longer be afforded. The time has come when we must balance the dollars needed for a sound, well-organized curriculum which will prepare a nurse

in the shortest time consistent with the volume of knowledge, the skills and attitudes to be learned. The assignment of a student nurse to care for patients without regard for her learnings is a waste of the student's and teacher's time, and an uneconomical use of the hospital's money. All hospital administrators must be familiar with the results of studies made to determine the costs of nursing education. Some of these are reliable, others are less valid. But facts appear in both which indicate that education in nursing costs money. Education is more than a mere by-product of the day by day care of hospital patients.

Review with me what the nurse is as defined by Miss Henderson. "She is," Miss Henderson says, "the consciousness of the unconscious, the love of life of the suicidal, the leg of the amputee, the eyes of the newly blind, a means of locomotion for the newborn, knowledge and confidence of the young mother, a 'mouthpiece' for those too weak to speak"

Do you not want that kind of nurse for the patients in the hospital you direct? Think of the implications for nursing education. There must be a sound basis of sciences, especially the social sciences. The clinical content will need to include whatever will enable her to carry her share in the medical team. The health, including mental health, and the community aspects must be included to prepare her to participate actively in a broad and continuing program of care and rehabilitation. ^{Only with} ~~Without~~ opportunity to learn to teach the patient ^{she develop} ~~she will lack~~ skill to help both patient and family to become increasingly self-dependent. Finally, of maximum importance in every area of the student nurse's learning, must be an experience with selected patients in carefully selected situations, and the necessary supervision which will assure her the opportunity to fulfil her learning needs. The focus of our educational

Sp. pt center on road or
is focus on carrying out
Her orders + keep admin. reg.

Have we ed. for pt care before
Organiz of keep makes this possible

1- Throwing away boomerang

program is set for us - it is the patient and his nursing care. Our methods of teaching are determined for us by principles of education - they will assure a curriculum adapted to the needs of the individual students. Our outcome cannot fail for we shall have a well-prepared nurse. Costly the preparation will be, but valuable indeed will be our product.

"A rise in tide means a lifting of all the boats." Time has brought a full tide of demand for nurses and nursing care. Whether we want to or not, we must raise our sights in nursing education if we would provide nursing care of high quality, and graduate nurses who find joy in providing such care as a part of the patient care team.

Needs affecting organs of pt case

Technical

Organizational

Medical - grouping to accomplish financial

Financial

General - com, partnership

Construction + equipment
Effect of depression

Within hospital -

Endowment
3rd party
Government

Social

Acceptance of hospital

Love favor - public - de
Law favor - profs -

Availability of personnel -
Feeling toward hospital

Prevalence - all in that pt during illness
prevalence from 1 fac to another depending
on pt's need -

Culture national
Symptoms

with race
-humanity

provision will be, but valuable insight will be our progress.
cannot fail for we shall have a well-prepared nurse. Justly the
are determined for us by principles of education - they will
is set for us - it is the patient and the nursing time. Our methods
"A rise in this world's thinking of all the people." - This has
full time of demand for nurses and nursing care. Whether we want
we must raise our sights in nursing education if we want to provide
higher care of high quality. The nurse must be who find joy in providing
each case as a part of the whole case care.

STAFF EDUCATION AND ADMINISTRATIVE RESPONSIBILITY
FOR THE BETTER CARE OF THE PATIENT

Staff education and administrative responsibility for the better care of the patient - to nurses familiar with the pattern of the hospital school of nursing, which combines responsibility for patient care and education, such a title should not seem strange. Over the generations superintendents of nurses have carried also the title of "Principal of the School of Nursing," and have succeeded in their plans for nursing care to the degree that the school of nursing under their direction prepared successful nurses. But, in the early days the school of nursing was the nursing service. Then began the gradual evolution of the all graduate nursing service, the graduate service supplemented by students having clinical experience, and finally today, the combination of professional nurse, practical nurse, student nurse, and auxiliary worker.

For the student, the educational emphasis is well founded in a school's curriculum. For the graduate nurse and the auxiliary worker there is no set pattern, no legal requirements to stimulate planning. Moreover, the graduate nurse is employed as a skilled worker, and it is too often thought the auxiliary worker can be trained quickly for the tasks assigned. Is the nursing service then to conduct an educational program? Is that a function of administration? It would be interesting indeed to have time to search through the old records, to see how the functions of administration in nursing have changed over the years as the pattern of nursing care has become more complex, and the nursing service personnel have been affected by changing social trends and augmented demands of local and national health services.

Nursing administration, as envisaged from early records of hospitals of seventy-five years ago, indicates four areas of responsibility.

STAFF EDUCATION AND ADMINISTRATIVE RESPONSIBILITY
FOR THE BETTER CARE OF THE PATIENT

Staff education and administrative responsibility for the better

care of the patient - to nurses familiar with the pattern of the hospital school of nursing, which combines responsibility for patient care and education, such a title should not seem strange. Over the generations superintendents of nurses have carried also the title of "Principal of the School of Nursing," and have succeeded in their plans for nursing care to the degree that the school of nursing under their direction prepared successful nurses. But in the early days the school of nursing was the nursing service. Then began the gradual evolution of the all graduate nursing service, the graduate service supplemented by students having clinical experience, and finally today, the combination of professional nurse, practical nurse, student nurse, and auxiliary worker.

For the student, the educational emphasis is well founded in

a school's curriculum. For the graduate nurse and the auxiliary worker

there is no set pattern, no legal requirements to stimulate planning.

Moreover, the graduate nurse is employed as a skilled worker, and it is too

often thought the auxiliary worker can be trained quickly for the same position.

Is the nursing service then to conduct an educational program? Is that a function

of administration? It would be interesting indeed to have time to search

through the old records to see how the functions of administration in nursing

have changed over the years as the pattern of nursing care has become more

complex, and the nursing service personnel have been affected by changing

social trends and expanding demands of local and national health services.

Nursing administration, as envisaged from early records of

hospitals of seventy-five years ago, indicates four areas of responsibility.

Technical
Nursing affecting organization of personnel

First, the area which I shall call business. To be sure that early superintendent of nurses would have disclaimed knowledge of budget or hospital accounting. One wonders what her reaction would be to the electric calculating machine, or to the I B M machines which work seemingly impossible miracles with statistics, today. But she was responsible often for the purchase of food and other supplies. That was business. She, too, must have struggled against the handicap of inadequate numbers of personnel, because the money for nursing was limited in amount. Bookkeeping must have been necessary.

Second, there was the area which I shall call maintenance. In part this must often have been her responsibility. There were directions to be given to carpenters and painters at times, and such work to be approved. Equipment - beds, tables and chairs, must have needed occasional repair. Linen which had to be washed, had also to be mended, and finally, when worn out, torn into bandages.

Third, there was the area which I shall call organization. In this area the early superintendent of nurses was responsible for developing a pattern within which lines of authority would be known and respected. Although she did not have job specifications written which she could give to workers, doubtless she could name the functions which each worker was to perform. On the whole, the area of organization must have been simple, for she was responsible to the hospital superintendent, and of the usual two nurses on each ward, the older in terms of employment was the head nurse - responsible to her.

The fourth area - if she had thought a name necessary, she might have called the area of employee interests. In this area fell many activities which this superintendent of nurses took as a matter of course, as she attempted to build and hold a staff which would function smoothly and effectively. There was the selection of pupil nurses and the other workers for whom she was

First, the area which I shall call business. To be sure that early experience of nurses would have diminished knowledge of budget or hospital accounting. One wonders what her reaction would be to the electric calculating machine, or to the I B M machine which work seemingly impossible miracles with statistics, today. But she was responsible often for the purchase of food and other supplies. That was business. She, too, must have struggled against the handicap of inadequate numbers of personnel, because the money for nursing was limited in amount. Bookkeeping must have been necessary. In fact

Second, there was the area which I shall call maintenance. In fact this must often have been her responsibility. There were directions to be given to carpenters and painters at times, and much work to be supervised. Equipment - beds, tables and chairs, must have needed occasional repair. Linen which had to be washed, had also to be mended, and finally, when worn out, torn into bandages.

Third, there was the area which I shall call organization. In this area the early superintendent of nurses was responsible for developing a pattern within which lines of authority would be known and respected. Although she did not have job specifications written which she could give to workers, doubtless she could name the functions which each worker was to perform. On the whole, the area of organization must have been simple, for she was responsible to the hospital superintendent, and of the usual two nurses on each ward, the older in terms of experience was the head nurse - responsible to her.

The fourth area - if she had thought a name necessary, she might have called the area of employee interests. In this area fell many activities which this superintendent of nurses took as a matter of course, as she attempted to build and hold a staff which would function smoothly and effectively. There was the selection of pupil nurses and the other workers for whom she was

responsible - the care of the workers who were ill - the talk with the ward tender or male employee whose work had gone badly because he had sat up at night with a sick wife - the discussion with the head nurse who never seemed to get on with the drug clerk - and the bedside teaching given to the new probationer who had arrived the day before.

How many similarities and differences nursing administration today will show in contrast! The business responsibilities have narrowed to the problem of budget. There are dietary, store, maintenance, purchasing, housekeeping, pharmacy departments; all to carry the special responsibilities within their designated scope. And so the director of nursing today can turn her attention to those activities through which the nursing service contributes to the better care of the patient. You will notice, I hope, that I omitted to say - "And so the director of nursing has time to turn her attention to nursing responsibilities as a result of this more modern institutional organization." But this is not the case, and so I omitted to say it.

The nursing service of the 1870's and 1880's was a simple, kindly service, involving few workers. Just to realize that there was no thermometer for the very earliest professional nurses, no stethoscope, no blood pressure machine, no hypodermic syringe, no intramuscular syringe for nurses to use; no X-Ray preparation; no laboratory tests as we know them now; no aseptic technique; no intensive medical research program. Just to realize these differences will speak for the differences between the two systems.

The nursing service of 1950 is a complicated, dynamic service, requiring many workers with many different types of experience, training and skills. In spite of this, there are similarities in the two systems which remain. First, there is the need for an organization structure, in which the lines of authority and responsibility are clear and appropriate, and the need for job specifications to show the worker where his or her responsibilities lie.

responsible - the care of the workers who were ill - the talk with the ward
leader or male employee whose work had come badly because he had not at night
with a sick wife - the discussion with the head nurse who never seemed to get
on with the first clerk - and the belated teaching given to the new probationer
who had arrived the day before.

How many specialties and differences nursing administration
today will know in contrast! The business responsibilities have narrowed
to the problem of budget. There are dietary, stores, maintenance, purchasing,
housekeeping, pharmacy department; all to carry the special responsibilities
within their designated scope. And so the director of nursing today can turn
her attention to those activities through which the nursing service contributes
to the better care of the patient. You will notice, I hope, that I omitted to
say - that so the director of nursing has time to turn her attention to nursing
responsibilities as a result of this more modern institutional organization.
But this is not the case, and so I omitted to say it.

The nursing service of the 1920's and 1930's was a simple, kindly
service, involving few workers. Just to realize that there was no thermometer
for the very earliest professional nurses, no stethoscope, no blood pressure
machine, no hypodermic syringe, no intramuscular syringe for nurses to use;
no X-ray preparation; no laboratory tests as we know them now; no nursing
techniques; no intensive medical research program. Just to realize these
differences will speak for the differences between the two systems.

The nursing service of 1950 is a complicated, dynamic service,
requiring many workers with many different types of experience, training and
skills. In spite of this, there are similarities in the two systems which
remain. First, there is the need for an organization structure, in which the
lines of authority and responsibility are clear and appropriate, and the need
for job specifications to show the worker where his or her responsibilities lie.

There is also need for the area which I have called the area of employee interest, in which employees are considered in relation to problems of personal adjustment, work adjustment, interdepartmental and intradepartmental relationships, teamwork, health, morale, and work contribution. The superintendent of nurses fifty years ago could know all of her employees personally. She could know the problems which would interfere with their work, and their lacks on the job. And the employees were secure, if she were the right type of leader, in her interest, and in the fact that she would see that they were trained day by day to do their jobs well. Today this area of administration is called personnel administration. It may be the special responsibility of one trained worker, employed by the institution for part or all of the employees. But the principles of personnel administration are the responsibility of every nurse who directs a nursing service, a division of the hospital, a single ward, or a nursing team. Personnel administration today, as many years ago, is the science of the development of people to the end that effective results with people are secured.

To return to the topic of this meeting - staff education and administrative responsibility for the better care of the patient. It is necessary to narrow the discussion to one aspect of personnel administration - the training of workers. Who comprises the staff which is to be educated? When is training indicated? What should be the plan? How can the results be measured?

For purposes of illustration I shall include in the staff any worker who gives service on the floor or ward which assists directly with the care of the patient. I shall have in mind the supervisor, head nurse, the practical nurse, the aide, the orderly, the ward helper, the ward clerk. As I list these it is evident that there is a wide diversity of work represented in the group. There are wide differences in experience, in education, in age, and in interests.

There is also need for the area which I have called the area of employee interest, in which employees are considered in relation to problems of personal adjustment, work adjustment, interdepartmental and interdepartmental relations, ship, teamwork, health, morale, and work contribution. The superintendant of nurses fifty years ago could know all of her employees personally. She could know the problems which would interfere with their work, and their lacks on the job. And the employees were secure, if she were the right type of leader, in her interest, and in the fact that she would see that they were trained day by day to do their jobs well. Today this area of administration is called personnel administration. It may be the special responsibility of one trained worker, employed by the institution for part or all of the employees. But the principles of personnel administration are the responsibility of every nurse who directs a nursing service, a division of the hospital, a clinic ward, or a nursing team. Personnel administration today, as many years ago, is the science of the development of people to the end that effective results with people are secured.

To return to the topic of this meeting - staff education and administrative responsibility for the better care of the patient. It is necessary to narrow the discussion to one aspect of personnel administration - the training of workers. Who comprises the staff which is to be educated? When is training indicated? What should be the plan? How can the results be measured?

For purposes of illustration I shall include in the staff any worker who gives service on the floor or ward which entails directly with the care of the patient. I shall have in mind the supervisor, head nurse, the practical nurses, the aide, the orderly, the ward helper, the ward clerk. As I list these it is evident that there is a wide diversity of work represented in the group. There are wide differences in experience, in education, in age, and in interests.

As all work together for a common purpose, each must cooperate closely at times with all others. Regardless of status, each must have certain functions for which she or he has responsibility. Each must understand her own place in the organization. Each must know how her functions fit with, or facilitate, the activities of all others. Each should respect the other worker for her contribution. Each should grow consistently toward greater effectiveness through her experience. Each should find satisfactions in her relationships with the others and pride in the team's accomplishment, and pride in her own individual contribution to the team's achievement.

In short, to have good patient care there must be first, informed workers; second, skilled workers; third, good group relationships; fourth, the worker must find satisfaction and pride in his work. Here are the objectives for an in-service or staff education program. All four purposes are equally important for all groups of workers. Used as guides to planning, such objectives indicate the need for a separate content for each group, for each group has different functions. There is also need for a common content, since all groups work in the same institution, and work together.

A staff education program divides naturally into three parts. First, the orientation of the new worker. Second, the training of the unskilled, or further training of the less adequately prepared worker to meet the needs of the assignment. Third, the continued plan for information and stimulation of the experienced, skilled worker. Obviously each group will need these three divisions in its program. For example, for the registered nurse there should be an orientation plan to introduce her to the institution; the personnel with whom she is to work; the ward, and its physical plan; the location of supplies; the methods peculiar to the institution in relation to such activities as charting or medications or special equipment of ward routines or unusual treatments. If the nurse is not familiar with the metric

As all work together for a common purpose, each must cooperate closely at times with all others. Regardless of status, each must have certain functions for which she or he has responsibility. Each must understand her own place in the organization. Each must know how her functions fit with, or facilitate, the activities of all others. Each should respect the other worker for her contribution. Each should grow constantly toward greater effectiveness through her experience. Each should find satisfaction in her relationship with the others and guide in the team's accomplishment, and pride in her own individual contribution to the team's achievement.

In short, to have good patient care there must be three things: first, workers; second, skilled workers; third, good group relationships. Fourth, the worker must find satisfaction and pride in his work. Here are the objectives for an in-service or staff education program. All four purposes are equally important for all groups of workers. Used as guides to planning, each objective indicates the need for a separate content for each group, for each group has different functions. There is also need for a common content, since all groups work in the same institution, and work together.

A staff education program divides naturally into three parts. First, the orientation of the new worker. Second, the training of the worker, or further training of the less adequately prepared worker to meet the needs of the assignment. Third, the continued plan for information and stimulation of the experienced, skilled worker. Obviously each group will need these three divisions in the program. For example, for the registered nurse there should be an orientation plan to introduce her to the institution; the personnel with whom she is to work; the ward, and its physical plan; the location of supplies; the methods peculiar to the institution in relation to such activities as charting or medication or special equipment or ward routines or unusual treatments. If the nurse is not familiar with the basic

system, and it is used in the institution, classes in the metric system would be included as part of this orientation.

The second aspect of the staff education program for nurses would include the training of the less adequately prepared worker. This may be necessary for the nurse who has been inactive over a number of years, or a nurse who lacks experience in such situations as she may be required to meet in the particular institution. For example, she may be unfamiliar with chest suction, with the respirator, with certain of the medications, or with the community referral plan.

Finally, the skilled nurse who has been a member of the staff for several years may find stimulation and satisfaction in learning about the evolving research program of the institution in which she shares in some small way; or the newest of the medications; or changes in the development of the team plan. She may need also some plan to help her maintain proper relationships with the community health agencies; with the medical staff; with the personnel and changing programs of the other departments of the hospital; with the evolving public relations program of the hospital.

The program for the licensed practical would be similar, but suited to her specific functions.

When the program for unskilled workers is considered, the situation will differ markedly in some respects. There will be here the worker who has had no previous association with a hospital; who must be oriented, and then trained in even the most simple duties. There will also be those in the unskilled group who have worked in hospitals, have even had similar titles, but whose preparation is none-the-less grossly inadequate. In this group, too, will be found men and women employed for some years who believe they are and

system, and it is used in the institution, classes in the metric system would be included as part of this organization.

The second aspect of the staff education program for nurses would

include the training of the less adequately prepared worker. This may be necessary for the nurse who has been inactive over a number of years, or a nurse who lacks experience in such situations as she may be required to meet in the particular institution. For example, she may be unfamiliar with chest suction, with the respirator, with certain of the medications, or with the community referral plan.

Finally, the skilled nurse who has been a member of the staff for

several years may find stimulation and satisfaction in learning about the evolving research program of the institution in which she serves in some small way; or the newest of the medications; or changes in the development of the team plan. She may need also some plan to help her maintain proper relationships with the community health agencies; with the medical staff; with the personnel and changing programs of the other departments of the hospital; with the evolving public relations program of the hospital.

The program for the licensed practical would be similar, but suited

to her specific functions.

When the program for unskilled workers is considered, the situation

will differ markedly in some respects. There will be here the worker who has had no previous association with a hospital; who must be oriented, and then trained in even the most simple duties. There will also be those in the unskilled group who have worked in hospitals, have even had similar titles, but whose preparation is none-the-less grossly inadequate. In this group, too, will be found men and women employed for some years who believe they are and

A. who are called "experienced", because they have been employed for many years. To these latter employees the need for further training may never be evident, yet these like the nurses who have been employed for several years, need the stimulation of continued training to hold them to the best level of their performance.

Why, we might say, does this type of educational program make such a difference? Why are not the workers of all types capable of doing their best work without constant instruction? Let us consider here what makes an effective worker, and what makes him continue to be an effective worker. First, to be effective, one must know how to do the job. Second, one must want to do the job well; week by week, year by year, as long as the individual is employed. She must not grow stale, or complacent; complacent in relation to the job or to her level of performance on the job, or to the amount of work accomplished. Third, she must have a continuing sense of accomplishment. Fourth, she must have a feeling of satisfaction in the work. Fifth, she needs above all, to know that her job is important to the success of the hospital as a whole. Sixth, the individual must find the right relationships between her daily work and her life outside the job.

Without a plan for in-service education some individuals can find some of these factors for themselves. Most individuals have the capacity to find but few, and so their work, their care of the patient, is not geared to the level of their best performance. The nursing service, therefore, which aims toward the improvement of nursing care, must include in its program a plan for staff education. Or, it might be said of the nursing service, as of any employing agency, that nursing service is obligated to furnish an in-service program, just as it is obligated to look after the health and general welfare of its workers. In a small institution the director of nursing will plan the program for her assistant and the head nurses and staff nurses. Her

who are called "experienced", because they have been employed for many years. To these latter employees the need for further training may never be evident, yet these like the nurses who have been employed for several years, need the stimulation of continued training to hold them to the best level of their performance.

Why, we might say, does this type of educational program make such a difference? Why are not the workers of all types capable of doing their best work without constant instruction? Let us consider here what makes an effective worker, and what makes him continue to be an effective worker. First, to be effective, one must know how to do the job. Second, one must want to do the job well; week by week, year by year, as long as the individual is employed. She must not grow stale, or complacent; complacent in relation to the job or to her level of performance on the job, or to the amount of work accomplished. Third, she must have a continuing sense of accomplishment. Fourth, she must have a feeling of satisfaction in the work. Fifth, she needs above all, to know that her job is important to the success of the hospital as a whole. Sixth, the individual must find the right relationships between her daily work and her life outside the job.

Without a plan for in-service education some individuals can find some of these factors for themselves. Most individuals have the capacity to find but few, and so their work, their care of the patient, is not related to the level of their best performance. The nursing service, therefore, which aims toward the improvement of nursing care, must include in its program a plan for staff education. Or, it might be said of the nursing service, as of any employing agency, that nursing service is obligated to furnish an in-service program, just as it is obligated to look after the health and general welfare of its workers. In a small institution the director of nursing will plan the program for her assistant and the head nurses and staff nurses. Her

1. assistant will plan for the auxiliary personnel. Director and assistant will meet together to study teaching problems. In a large institution this necessitates many programs - the director of nurses plans for the assistant administrators and supervisors - the assistant administrator plans for the head nurses - the supervisors and head nurses plan for the staff nurses. The administrator plans for the teachers. A special supervisor may be assigned full time to the lay personnel, the aides, the orderlies, the ward helpers, the maids and ward clerks. Or supervisor and head nurse may plan for any one of these groups. There is no set pattern. The size of the institution, the numbers and preparation of the staff, the allocation of functions, will determine the possibilities. The important factor is that there is a plan. For the institution which provides no systematic plan for this in-service education, haphazard and misdirected teaching will be used to fill the need, and the results of such a plan are apt to be frustration, unhappiness, and poor patient care. There is nothing mysterious about an in-service education program. As in any plan for instruction or teaching the principles of education apply. There must be the selection of the purpose; the choice of the teaching content to accomplish the purpose; the adaptation of method to the group, the situation, and the desired outcomes.

Two new factors, or perhaps I should say two factors not always given proper emphasis are participation of the employee in the program planning for his group, and second, of which the first is a part, the emphasis on personnel relations, or human relations. It sounds strange as I write these words "human relations" to think that nurses whose lives have been spent working to care for human beings should have need to discuss human relations. But we have many characteristics inherited from our wise and foresighted forebears, who worked under different situations in a different kind of world, and one of those characteristics is the lack of the science of human relations in dealing with our co-workers. In the

assistant will plan for the auxiliary personnel. Director and assistant will meet together to study teaching problems. In a large institution this necessitates many programs - the director of nurses plans for the nursing administrators and supervisors - the assistant administrator plans for the head nurses - the supervisors and head nurses plan for the staff nurses. The administrator plans for the teachers. A special supervisor may be assigned full time to the lay personnel, the aides, the orderlies, the ward helpers, the midlets and ward clerks. Or supervisor and head nurse may plan for any one of these groups. There is no set pattern. The size of the institution, the numbers and preparation of the staff, the allocation of functions, will determine the possibilities. The important factor is that there is a plan. For the institution which provides no systematic plan for this in-service education, haphazard and misdirected teaching will be used to fill the need, and the results of such a plan are apt to be frustration, unhappiness, and poor patient care. There is nothing mysterious about an in-service education program. As in any plan for instruction or teaching the principles of education apply. There must be the selection of the purpose; the choice of the teaching content to accomplish the purpose; the adaptation of method to the group, the situation, and the desired outcomes.

Two new factors, or perhaps I should say two factors not always given proper emphasis are participation of the employee in the program planning for his group, and second, of which the first is a part, the emphasis on personnel relations or human relations. It sounds strange as I write these words "human relations" to think that nurses whose lives have been spent working to cure for human beings should have need to discuss human relations. But we have many characteristics inherited from our wise and forethoughted forebears, who worked under different situations in a different kind of world, and one of those characteristics is the lack of the science of human relations in dealing with our co-workers. In the

past the patient was the end and all of the efforts. The worker was important, not as an individual, but as a worker and to the degree to which he or she assisted in the care of the patient. And workers were plentiful. The patient's care is no less important today. There is no less emphasis on that care, but we do know today, in this particular social era, that effective results from people will only be secured when people have opportunity to develop as people.

When a nursing service considers a broad plan, which sounds new and perhaps a bit radical, someone invariably asks "How much will it cost?" If nursing service could only know how much time and effort is now being wasted because of the lack of such a plan, there would be a tangible satisfactory answer. Obviously, the program in any institution cannot be the responsibility of any one person. If the institution is a small one and the staff is prepared and can add to its existing load, the plan may be put into effect without additional personnel provided. The director, or her assistant, can give the proper leadership to the other participants. If the institution is large, several new supervisors may be needed. However, the savings in personnel turn-over, the reduced absenteeism, the reduced wastage of supplies and hours, the improvement in the spirit of the workers has in the past shown that the product of the worker is of improved quality. So we might well say that the improvement of the care of the patient may more than compensate for the added salaries.

This previous statement sounds as if I offer in-service education as the panacea for all the ills of shortage and poor work. It should be emphasized again, that in-service education is but one phase of a sound personnel administration program. It is the program as a whole, of course, which counts, and every institution should today have a sound personnel administration program. But the participation of the employees in planning an in-service education program will serve to strengthen the personnel administration program as a whole, for representatives of each group who help to plan for

past the patient was the end and all of the efforts. The worker was important, not as an individual, but as a worker and to the degree to which he or she assisted in the care of the patient. And workers were plentiful. The patient's care is no less important today. There is no less emphasis on that care, but we do know today, in this particular social era, that effective results from people will only be secured when people have opportunity to develop as people.

When a nursing service considers a broad plan, which sounds new and perhaps a bit radical, someone invariably asks "How much will it cost?" If nursing service could only know how much time and effort is now being wasted because of the lack of such a plan, there would be a terrific satisfactory answer. Obviously, the program in any institution cannot be the responsibility of any one person. If the institution is a small one and the staff is untrained and can add to its existing load, the plan may be put into effect without additional personnel provided. The director, or her assistant, can give the proper leadership to the other participants. If the institution is large, several new supervisors may be needed. However, the savings in personnel turnover, the reduced absenteeism, the reduced wastage of supplies and hours, the improvement in the spirit of the workers has in the past shown that the product of the worker is of improved quality. So we might well say that the improvement of the care of the patient may more than compensate for the added salaries.

This previous statement sounds as if I offer in-service education as the answer for all the ills of shortage and poor work. It should be emphasized again, that in-service education is but one phase of a sound personnel administration program. It is the program as a whole, of course, which counts, and every institution should today have a sound personnel administration program. But the participation of the employee in planning an in-service education program will serve to strengthen the personnel administration program as a whole, for representatives of each group who help to plan for

1 their group will bring to the administration of the nursing service needs and problems to use in improving the employees' health program, the plan for selection of employees, suggestions for improving working conditions (and I do not refer here just to pay). All those factors which assist in the maintenance or establishment of good group or institutional morale, the catalytic agent which turns knowledge and skill into effective patient care.

It is not possible to tell a director of nursing service just how to organize her particular program. It is not possible to adopt the program of one institution and put it into effect just as it is used in another institution. The purpose of an in-service program is to enable the auxiliary worker and the nurse in a specific institution to give the best possible care to the particular group of patients under the circumstances peculiar to that one institution. Ideas from reports of general planning from other institutions are helpful. The knowledge that other institutions can introduce a program is stimulating. To hear the struggles of another nursing service director against group disinterest, or lack of participation, helps to relieve frustrations. But each institution must have its own program fitted to its own particular personnel, and their specific needs in the particular situation.

The program may begin as a means of helping the workers to see their places in the care of the patient. Or better yet, the plan may begin when the director of nursing sits down with her assistants and supervisors to discuss the need for a program. Such a meeting will develop attitudes toward the work and the worker, open eyes to poor work, build concepts of what good patient care really means, or what the possibilities are for better educational programs. Regardless of where or how the tangible program appears to have started actually the first thinking and planning must be the responsibility of the director of nursing.

their group will bring to the administration of the nursing service needs and problems to use in improving the employees' health program, the plan for selection of employees, suggestions for improving working conditions (and I do not refer here just to pay). All these factors which exist in the maintenance or establishment of good group or institutional morale, the catalytic agent which turns knowledge and skill into effective patient care.

It is not possible to tell a director of nursing service just how to organize her particular program. It is not possible to adopt the program of one institution and put it into effect just as it is used in another institution. The purpose of an in-service program is to enable the auxiliary workers and the nurse in a specific institution to give the best possible care to the particular group of patients under the circumstances peculiar to that one institution. Ideas from reports of general planning from other institutions are helpful. The knowledge that other institutions can introduce a program is stimulating. To hear the struggles of another nursing service director against group dissension, or lack of participation, helps to relieve frustrations. But each institution must have its own program fitted to its own particular personnel and their specific needs in the particular situation.

The program may begin as a means of helping the workers to use their places in the care of the patient. Or better yet, the plan may begin when the director of nursing sits down with her assistants and supervisors to discuss the need for a program. Such a meeting will develop attitudes toward the work and the worker, open eyes to poor work, build concepts of what good patient care really means, or what the possibilities are for better educational programs. Regardless of where or how the tangible program appears to have started actually the first thinking and planning must be the responsibility of the director of nursing.

The plan for in-service education must be the plan of all who share in it. Complacency, intolerance, dislike, will be met. But the results will gradually begin to show if you will believe in your own work, in people, in the principle, and in your profession. You will also need to believe in yourself and your own potentialities for good. Unless you are ready to do this, you cannot expect the workers in your service, or the students in your educational program, or the patients under your care, to rely on your leadership.

Integrity

Integrity is a word that should go hand-in-hand with profession. Not to stretch a point too far, it should even be ^{nurse} synonymous with dentist.

Integrity is a moral principle of soundness -- strictness in fulfilling contracts, freedom of corruption in rendering service. In the practice of ^{hygiene} dentistry, it is often challenged by time limits, habit, and outside influence of current trends.

Because of comparative isolation, lack of monitorship, privacy of ministrations, and very uniqueness of possession of certain skills and knowledge, the ^{nurse} dentist cannot shift ^{his} responsibilities to the shoulders of another outside his profession. Things ^{hygiene} dental begin and end with the ^{nurse} dentist. There is no other recourse.

The boundaries of integrity are not limited in compass to a pay-for-service category. In our domain it embraces every phase of ^{nurse} dentist-patient relations from ^{admission} examination through completion of ^{care} treatment, including patient education and counsel in prevention of ^{care for self at home} dental disease. It should pervade officer-membership kinship and dominate citizen-community esprit de corps.

The exercise of integrity requires courage and unselfishness and, sometimes, suppression of ego. It draws a finer bead on conduct than legal restraint or the discipline of ethics. Flagrant violation of the law and wide detour around the principles of professional ethics may be dealt with by others. But lack of integrity is a matter to be judged by a court of conscience. If settled here it will never qualify for further judgment.

A ~~man~~^{person} may be an expert in the use of firearms or operation of a motor vehicle, but if he lacks courtesy, honesty, and altruism he is a menace to society and a threat to the safety of others. By the same token, a ^{nurse} dentist may be well educated and highly skilled in his field, but if ~~he~~^{she} lacks integrity ^{& her school} she is a discredit to ~~his~~ profession and obstructs the rights of those who entrust themselves to his care.

Integrity puts most other virtues begging, because the latter are needed only to make life more bearable where the former ceases to exist. More than any other virtue, it is the one that has made our profession a noble one down through the years. It is a part of our heritage that should not be forgotten. ^{And it should be a part of the nature of the} (Brough, R. D., D.M.D., Editorial: Bulletin, Fifth Dental Society, State of New York, October 1959) ^{Student in the School} of nursing, a part never to be weakened ^{because courage} but always ^{or} to be strengthened to the end that life as a nurse ^{the easiest way is} may be rewarding and the School & Hospital continue to be held in high esteem - No one can make you or me a person of integrity. But if we have it not others will suffer and our ^{opportunities} ~~lives~~ made narrow because we ourselves are small. Integrity is a word that should go hand in hand with profession. It should even be synonymous with the word nurse.

RS:BF

1-6-60

United States Navy Medical News Letter, Vol. 35, Friday, 1 January 1960 No. 1

1-123 : 1 D13-162 Superintendent of Police

1 School of Nursing

